ARTICLES

REGULATING FOR BIRTH JUSTICE

by
Jamille Fields Allsbrook[*]

Impacted persons have shared accounts of traumatic birthing experiences, and advocates have raised the alarm on the urgent need to advance birth justice. Despite this raised awareness, women and birthing people are still dying and suffering unnecessarily. Even more, systems are still structured to impede birthing choices, particularly those from marginalized communities such as Black and Indigenous women. Notably, over 80% of U.S. maternal deaths are preventable, according to federal government data. Ironically, the same laws and systems that have created, perpetuated, and tolerated birth injustices can be leveraged to move the country towards birth justice. On the national level, federal agencies are positioned to address complicated health care issues such as maternal health inequities, and executive branch interventions are a necessary complement to congressionally enacted laws and judicially created rights.

Congress has directed the Department of Health and Human Services (HHS) to advance the nation's health and well-being, including pregnant and

---

[*] Jamille Fields Allsbrook is an assistant professor at Howard University School of Law. I would like to thank Sidney Watson and Chad Flanders for their insight and edits throughout the process, and a special thanks to Elizabeth Kukura, Valarie Blake, Andrele St. Val, and Tomar Pierson-Brown for lending their expertise to this project. Additional thanks to the participants of the Association of American Law School's Law, Medicine and Healthcare and the News Voices in Administrative Law workshops, including readers Seema Mohipatra and Jodi Short for their thoughtful edits and suggestions. Finally, this project would not have been possible without the research assistance of MacKenzie Beaver, Julie Tran, Camille Moreno Jimenez and Madeline Tatro, and the tremendous editing and reference checking from the editors at the Lewis & Clark Law Review.

birthing people. To illustrate, this Article outlines select statutory provisions granting federal administrative agencies the authority to act pursuant to the Affordable Care Act, Medicaid, and the Public Health Service Act statutes. This Article also outlines how the federal government has exercised existing authorities to improve health care access and quality, while also outlining how government actions have created and perpetuated maternal health inequities. Finally, this Article proposes policy recommendations for HHS, while also tracking how recent efforts threaten maternal health outcomes.

Despite political and legal hurdles to regulatory and other administrative actions, there remains a path forward. The Supreme Court overturned the Chevron *deference doctrine in* Loper Bright Enterprises v. Raimondo *and revived the major questions doctrine in* West Virginia v. EPA. *These cases represent a significant hurdle to a robust regulatory agenda, but the decisions are not insurmountable. There is no doubt that the shifting legal landscape will limit agencies' ability to address maternal health inequities and no one action alone will solve the decades-old systemic failures. However, regulators can—and should—continue to move forward pursuant to clear statutory authorities and consistent with long-standing regulations. But, of course, there must be a functioning federal government to implement health laws, and gutting the federal government could be insurmountable. The dismantling of the federal government represents not only a failure to progress, but a retrenchment backwards, threatening pregnant people's lives. Even more, a failure to stop the administrative state from crumbling is a birth justice issue and a public health concern. Through examining the maternal health crisis, this Article illustrates the human costs of allowing the administrative state to crumble.*

Introduction 651
I. Situating Birth Injustices 659
  A. *Birth Justice Principles* 660
  B. *Assessing the Problem* 662
  C. *The System Was Built Inequitable* 667
II. The Federal (Government) Determinants of Health 674
  A. *Executive Qualifications and Statutory Obligations* 676
    1. *Oversight and Enforcement* 677
    2. *Quality of Care* 679
    3. *Perinatal Workforce Development* 681
    4. *Provider Access* 682
    5. *Health Insurance Quality* 683
    6. *Research and Assessments* 686
  B. *Missed Opportunities and Policy Recommendations* 688
    1. *No Accountability for Discrimination* 689

2. *Perverse Payment Incentives* 693
3. *Maternity Workforce Shortage* 697
4. *Limited Provider Networks* 702
5. *Health Insurers Not Covering Wanted and Needed Care* 706
6. *Gaps in Measurement and Assessment* 710
C. *The Path Backward* 713
III. Overcoming Barriers to an Administrative Response 719
A. *Politics and Congress* 719
B. *The Courts* 723
1. Chevron *Deference Doctrine* 723
2. *Major Questions Doctrine* 727
a. *What Is Major?* 727
b. *What Is Clear?* 729
Conclusion 732

INTRODUCTION

Kira Dixon Johnson died at Cedars-Sinai Hospital following the birth of her second son.[1] Ms. Johnson's death resulted from hemorrhaging after a prescheduled cesarean section surgery. She had been in good health, and she had an uncomplicated pregnancy.[2] According to a federal civil rights complaint Ms. Johnson's family filed, there were several care failures that led to her death.[3] Her husband, Charles Johnson, claims that his concerns were ignored, and a nurse told him as he watched his wife's catheter turn pink then red with blood, "Sir, your wife just isn't a priority right now."[4] It was later concluded that Ms. Johnson slowly bled to death over 12 hours.[5] Even more, Ms. Johnson suffered additional harms before her death. The complaint states Ms. Johnson "suffered intense pain, anxiety, humiliation, fear, and emotional distress as she was dying and losing her husband and sons."[6] Lastly, Ms. Johnson, a Black woman, along with other women of color

---

[1] Deena Zaru & Brittany Gaddy, *Cedars-Sinai Medical Center Facing Federal Probe Over Treatment of Black Mothers*, ABC NEWS (July 12, 2023, at 11:48 PT), https://abcnews.go.com/US/cedars-sinai-medical-center-facing-federal-probe-treatment/story?id=101165260 [https://perma.cc/JEV6-KNTC].

[2] Kristi Pahr, *'My Wife's Legacy Gives a Voice to the Voiceless': Charles Johnson's Loss Launched a Maternal Health Revolution*, PARENTS MAG. (Apr. 10, 2020), https://www.parents.com/pregnancy/giving-birth/stories/my-wifes-legacy-gives-a-voice-to-the-voiceless-charles-johnsons-loss-launched-a-maternal-health-revolution/ (on file with the Lewis & Clark Law Review).

[3] Complaint for Damages for Discrimination & Disparate Health Care Treatment & Racism in Med. at 9–10, Johnson v. Cedars-Sinai Health Sys., No. 22STCV14868 (Cal. Super. Ct. May 3, 2022) [hereinafter Complaint for Damages for Discrimination].

[4] Pahr, *supra* note 2; Complaint for Damages for Discrimination, *supra* note 3, at 8.

[5] Complaint for Damages for Discrimination, *supra* note 3, at 5.

[6] *Id.* at 9.

treated in the hospital, did not receive the same care as white women.[7] The family's complaint does not mince words: "She would be alive today if she was a [w]hite woman."[8]

The personal accounts of childbirth trauma—including those from celebrities, such as Serena Williams and Beyoncé—along with the advocacy of doulas, midwives, patients, and mothers, has brought renewed attention to the decades-old maternal health crisis.[9] The United States has the worst maternal mortality and morbidity rate among developed nations,[10] with Black and Indigenous communities being the most impacted.[11] Even beyond the deaths, there are other undercounted maternal morbidities, life-altering events, mistreatment, and disrespect that birthing people continue to experience in this country.[12] While each of the women and birthing people behind these statistics have their own experiences and trauma, and each loss and adverse outcome represents its own unique injustice, there are common behaviors and practices contributing to each death, near death encounter, poor health outcome, and humiliation.[13]

---

[7] *See* Marissa Evans, *Cedars-Sinai Faces Federal Civil Rights Investigation Over Treatment of Black Mothers*, L.A. TIMES (July 11, 2023, at 05:00 PT), https://www.latimes.com/california/story/2023-07-11/cedars-sinai-facing-federal-civil-rights-investigation-over-treatment-of-black-mothers [https://perma.cc/EUN4-MUHE] (reporting on a federal civil rights investigation over how the hospital "treats Black women who give birth there").

[8] Complaint for Damages for Discrimination, *supra* note 3, at 5.

[9] *See, e.g.*, Jacqueline Howard, *Beyoncé and Serena Williams Bring Attention to Risks of Childbirth for Black Women*, CNN (Aug. 6, 2018, at 16:52 EDT), https://www.cnn.com/2018/08/06/health/beyonce-vogue-pregnancy-complication-bn/index.html [https://perma.cc/W3VS-APUW] ("[A]dvocacy—whether it's a patient advocating for herself or women advocating for each other—also remains important in addressing issues related to maternal health and maternal mortality.").

[10] Roosa Tikkanen, Munira Z. Gunja, Molly FitzGerald & Laurie C. Zephyrin, *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries*, COMMONWEALTH FUND (Nov. 18, 2020), https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries [https://perma.cc/M8GK-QQLL].

[11] DONNA L. HOYERT, CTRS. FOR DISEASE CONTROL & PREVENTION: NAT'L CTR. FOR HEALTH STAT., MATERNAL MORTALITY RATES IN THE UNITED STATES, 2021, at 1, 4 fig. 1 (2023), https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.pdf [https://perma.cc/R487-DBZZ]; Latoya Hill, Alisha Rao, Samantha Artiga & Usha Ranji, *Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them*, KFF (Dec. 3, 2025), https://www.kff.org/racial-equity-and-health-policy/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them/ [https://perma.cc/9T5Z-V4UV].

[12] S*ee generally* Elizabeth Kukura, *Obstetric Violence*, 106 GEO. L.J. 721 (2018) (discussing the systemic abuse, coercion, and disrespect that birthing people experience during childbirth in the United States).

[13] This Article aims to use inclusive language and, therefore, refers to "birthing people,"

Even more, there are common systemic barriers impeding maternal health outcomes, which become apparent when women, birthing people, providers, perinatal workers, and families recount their prenatal, birthing, and postpartum experiences:

- "[A] client who was not part of the prenatal program had hypertension which developed into toxemia . . . The swelling didn't recede—she needed help [but didn't know it]. She was only 19. She was 37 weeks along when she died . . . They found her in a coma. Her mom had to bury her and the baby."[14]
- "My son's doctor said he didn't weigh enough at four months. He was not underweight, just not close enough to the average for her to be comfortable. So she told me to start him on formula and that she would have to call social services if I didn't start supplementing. . . . She did not want to discuss other options with me. . . . I . . . felt blackmailed into the change."[15]
- "There's not a respect of the American Indian values that are important . . . [during birth]. You're shipped out to the clinic in the white town or the white hospital. And they treat you like a second class citizen because they know they're not going to get paid as much as someone who has regular insurance who's not getting care through contract health [from the IHS]. It's like you're a piece of cattle as opposed to a human being that deserves the same care and respect as someone else."[16]
- "We are really hobbled by systems and institutions that have embedded . . . racist ways of being, racist policies, procedures. . . . We recognize where things are unjust, and yet we are not really willing to dismantle, to decolonize, to take apart and rebuild something that is so clearly not safe, not fair, not just."[17]

---

given that not every person with the capability to become pregnant identifies as a woman. However, there is inadequate and inconsistent data on transgender and gender nonbinary people who become pregnant and their maternal mortality and morbidity rate. References to specific data will often refer to women only.

[14] Amnesty International, *Deadly Delivery: The Maternal Health Crisis in the USA*, at 6, Index AMR 51/007/2010 (Mar. 10, 2010) (alteration in original).

[15] EUGENE R. DECLERCQ, CAROL SAKALA, MAUREEN P. CORRY, SANDRA APPLEBAUM & ARIEL HERRLICH, CHILDBIRTH CONNECTION, LISTENING TO MOTHERS III: PREGNANCY AND BIRTH 34 (2013), https://nationalpartnership.org/wp-content/uploads/2023/02/listening-to-mothers-iii-pregnancy-and-birth-2013.pdf [https://perma.cc/5N4L-49XG] (alteration in original).

[16] Amnesty International, *supra* note 14, at 24 (alteration in original).

[17] NORA ELLMANN, CTR. FOR AM. PROGRESS, COMMUNITY-BASED DOULAS AND MIDWIVES: KEY TO ADDRESSING THE U.S. MATERNAL HEALTH CRISIS 18 (2020),

These stories highlight low-quality care, a lack of choice in care, coercive practices, and the racism women and birthing people report experiencing in accessing maternity care. These experiences are not the result of one-off bad actors but reflect problems in delivery of care and payment systems. Notably, over 80% of U.S. maternal deaths are preventable, according to the Centers for Disease Control and Prevention (CDC)[18]—which demonstrates that there are behaviors and practices leading to these deaths. Yet the well-deserved attention has not diminished the problem.[19]

Developing from within the reproductive justice movement, there is an emerging advocacy movement underway to pursue what advocates have termed "birth justice."[20] Birth justice is not just the absence of preventable deaths and adverse health outcomes, it is the attainment of healthy—even joyous—prenatal, birthing, and postpartum experiences. Birth justice can serve as a useful framework to assess current U.S. systems and to develop goals the law and policy should pursue. Achieving birth justice requires removing organizational and systemic barriers that lead to poor health outcomes. Even still, birth justice requires more than negative rights: it also requires an investment into the resources, supports, and education needed to allow women and birthing people meaningful decisions in their prenatal, pregnancy, and postpartum periods. By this measure, the United States is far from achieving birth justice for women and birthing people.

Birth justice cannot be achieved without federal administrative actions. First, the federal government has systematically erected and perpetuated birth injustices.

---

https://www.americanprogress.org/wp-content/uploads/sites/2/2020/04/DoulasMidwives-report.pdf [https://perma.cc/B877-CUM2] (alteration in original).

[18] *Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees*, CTRS. FOR DISEASE CONTROL & PREVENTION (Aug. 22, 2025), https://www.cdc.gov/maternal-mortality/php/data-research/index.html [https://perma.cc/3GBG-ZWJE] (providing maternal mortality data for 2017–2019 (84.2%), 2020 (83.5%), and 2021 (87%)); *see also* Press Release, Ctrs. for Disease Control & Prevention, Four in 5 Pregnancy-Related Deaths in the U.S. Are Preventable (Sep. 19, 2022), https://archive.cdc.gov/#/details?url=https://www.cdc.gov/media/releases/2022/p0919-pregnancy-related-deaths.html [https://perma.cc/C4X7-Y26D] (citing data from 2017–2019).

[19] *See generally* HOYERT, *supra* note 11 (reporting significant rises in U.S. maternal mortality rates across races—and especially among Black women—in 2021); *see also* Munira Z. Gunja, Evan D. Gumas & Reginald D. Williams II, *The U.S. Maternal Mortality Crisis Continues to Worsen: An International Comparison*, COMMONWEALTH FUND (Dec. 1, 2022), https://www.commonwealthfund.org/blog/2022/us-maternal-mortality-crisis-continues-worsen-international-comparison (on file with the Lewis & Clark Law Review) (documenting how the maternal mortality rate in the United States has "spiked in recent years," with Black women facing "more than double the average rate and nearly three times higher than the rate for white women").

[20] *What We Believe: Birth Justice Framework*, S. BIRTH JUST. NETWORK, https://southernbirthjustice.org/birth-justice-1 [https://perma.cc/8FBJ-W8BV] (last visited Dec. 30, 2025).

Government actions and inactions both historically and currently tolerate discriminatory, low-quality care, perverse payment incentives, maternity care deserts, limited choice in birthing support, inadequate insurance coverage, and insufficient data on the problem.[21] Therefore, the federal government is uniquely situated to address these systemic failures. Second, administrative agencies often have the subject matter expertise and the ability to adopt nuanced, granular policies to address shifting public health needs.[22] Further, Congress enacted laws tasking federal agencies with improving the health and well-being of people in the nation, including pregnant and birthing people.[23]

Many congressionally enacted laws simply would not be meaningful without agency implementation or enforcement. For example, the U.S. Department of Health and Human Services (HHS) conducted a civil rights investigation and reached an improvement plan agreement with Cedars-Sinai Hospital regarding the death of Kira Dixon Johnson.[24] Such actions should not cease. Even still, there are more actions the federal government could have taken to hold the hospital, and others like it, accountable for the alleged discriminatory care that Ms. Johnson experienced. Further, there are numerous regulations, policies, or guidance that can help mitigate or prevent such care. No one regulation, guidance, or enforcement action can solve structural inequities in health care, but when utilized strategically and across relevant federal agencies, administrative actions are a realistic and tangible path toward birth justice.

Federal agencies have played a key role in addressing maternal health inequities, under both democratic and republican presidents.[25] For example, under President Donald Trump's first Administration, HHS launched the Improving Maternal Health in America Initiative,[26] and pursuant to that

---

[21] *See infra* Section I.C.

[22] *See infra* Part II.

[23] *See, e.g.*, 42 U.S.C. § 254c-21(a) (authorizing the Secretary of Health and Human Services to develop best practices to improve maternal health outcomes).

[24] Evans, *supra* note 7; U.S. DEP'T OF HEALTH & HUM. SERVS., OFF. FOR C.R., OCR NO. 22-479470, VOLUNTARY RESOLUTION AGREEMENT BETWEEN THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE FOR CIVIL RIGHTS AND CEDARS-SINAI MEDICAL CENTER (2025) [hereinafter VOLUNTARY RESOLUTION AGREEMENT]; *see supra* text accompanying notes 1–8.

[25] *See, e.g.*, U.S. DEP'T OF HEALTH & HUM. SERVS., HEALTHY WOMEN, HEALTHY PREGNANCIES, HEALTHY FUTURES: ACTION PLAN TO IMPROVE MATERNAL HEALTH IN AMERICA 2–3 (2020) [hereinafter HEALTHY WOMEN, HEALTHY PREGNANCIES], https://aspe.hhs.gov/sites/default/files/private/aspe-files/264076/healthy-women-healthy-pregnancies-healthy-future-action-plan_0.pdf [https://perma.cc/78HP-7WP9]; THE WHITE HOUSE, WHITE HOUSE BLUEPRINT FOR ADDRESSING THE MATERNAL HEALTH CRISIS 3 (2022), https://bidenwhitehouse.archives.gov/wp-content/uploads/2022/06/Maternal-Health-Blueprint.pdf [https://perma.cc/JJJ9-MLJG].

[26] HEALTHY WOMEN, HEALTHY PREGNANCIES, *supra* note 25, at 2–3, 6–15 (summarizing

initiative, the agency published multiple maternal health reports including *Healthy Women, Healthy Pregnancies, Healthy Futures: Action Plan to Improve Maternal Health In America*, which outlined both planned and ongoing administrative actions to improve maternal health.[27] Similarly, in 2022, the Administration under President Joe Biden published *The White House Maternal Health Blueprint for Addressing the Maternal Health Crisis*, where various federal agencies outlined a series of commitments to advance maternal health.[28] Beyond any one specific president or presidential candidate, proposals for the federal government to address maternal health and build healthy families have been touted across the political spectrum. Conservatives have stated that improving maternal and infant health should be a priority within its "pro family" agenda,[29] and liberals have called for prioritizing maternal health among efforts to improve reproductive rights and bodily autonomy.[30] Illustratively, the liberal think tank the Center for American Progress has put out a comprehensive plan on addressing maternal health.[31] Even Project 2025—the Heritage Fund-created conservative plan, which has a chief goal to drastically reduce the size of the federal government—includes a plan for maternal and child health programs to fund and expand access to doulas, who provide nonmedical support before, during, and after labor and delivery.[32] These plans, undoubtedly, are different in scope and focus in certain key respects, and thus each plan differs significantly in the extent that it would move the nation closer to achieving birth justice. Even still, each

---

the problem of maternal mortality and morbidity in the United States and outlining an action plan to combat it); *HHS Initiative to Improve Maternal Health*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://aspe.hhs.gov/topics/public-health/hhs-initiative-improve-maternal-health [https://perma.cc/2WML-9NZ8] (last visited Dec. 27, 2025) (announcing and summarizing the HHS' initiative to improve maternal health under the first Trump Administration).

[27] HEALTHY WOMEN, HEALTHY PREGNANCIES, *supra* note 25, at 82–173; *see also* U.S. DEP'T OF HEALTH & HUM. SERVS., THE SURGEON GENERAL'S CALL TO ACTION TO IMPROVE MATERNAL HEALTH 7–10, 42 (2020), https://www.hhs.gov/sites/default/files/call-to-action-maternal-health.pdf [https://perma.cc/C5AP-C97H] (showing an additional report on the maternal health in the U.S. and announcing a "call to action" to resolve this crisis).

[28] THE WHITE HOUSE, *supra* note 25, at 3–7.

[29] *See, e.g.*, Patrick T. Brown & Brad Wilcox, *A New Family Policy Agenda from House Republicans*, INST. FOR FAM. STUD. (Oct. 10, 2022), https://ifstudies.org/blog/a-new-family-policy-agenda-from-house-republicans [https://perma.cc/6F78-VG4E].

[30] *See, e.g.*, THE WHITE HOUSE, *supra* note 25, at 3.

[31] *See* JAMILA TAYLOR, CRISTINA NOVOA, KATIE HAMM & SHILPA PHADKE, CTR. FOR AM. PROGRESS, ELIMINATING RACIAL DISPARITIES IN MATERNAL AND INFANT MORTALITY: A COMPREHENSIVE POLICY BLUEPRINT 3 (2019), https://www.americanprogress.org/wp-content/uploads/sites/2/2019/04/Maternal-Infant-Mortality-report.pdf [https://perma.cc/V3NW-TR7V].

[32] Roger Severino, *Department of Health and Human Services*, *in* MANDATE FOR LEADERSHIP: THE CONSERVATIVE PROMISE 449, 449–52, 486–87 (Paul Dans & Steven Groves eds., 2023).

plan reflects a recognition from opposite ends of the political spectrum that federal administrative agencies can play a role in addressing maternal health.[33]

As the federal government, and subsequently the administrative state, shift unlike any other time in history, lawmakers and advocates must not lose sight of what is at stake: in this instance, it is women and birthing people's lives and health. Given the role that the federal government has had in tolerating and perpetuating but also in addressing maternal health equity, the dismantling of the federal government represents a drastic step backwards in the movement to advancing birth justice. Beyond the current political moment, there is concern that remaining regulators will be afraid to pursue a robust regulatory agenda going forward.[34] The Supreme Court's recent rulings overturning the *Chevron* deference doctrine and the resurrection of the major questions doctrine have limited agency deference and represent a narrow interpretation of regulatory authority.[35] These decisions, as well as the inherent limitations placed on administrative agencies, raise reasonable questions as to whether it is strategic to implement maternal health policies through regulations, guidance, or other agency action when the decades-long conservative push to limit the administrative state is apparently succeeding.[36] Even still, I offer here that there are still reasons to pursue policies administratively, and a path forward remains. There are existing statutory authorities that administrators and regulators could—and at times are statutorily obligated to—act pursuant to in order to improve maternal health outcomes.[37] Highlighted within this Article are statutory authorities deriving from the Affordable Care Act (ACA) and Medicaid statutes, as well as statutes governing the Health Resources and Services Administration

[33] Notably, these proposals differ in the focus on public–private partnerships, the commitment to addressing racial disparities, and the recognition that family planning and reproductive health care are linked to maternal health outcomes. *See* HEALTHY WOMEN, HEALTHY PREGNANCIES, *supra* note 25, at 36, 45, 78; THE WHITE HOUSE, *supra* note 25, at 23, 30, 43.

[34] Governing for Impact articulates the concern: "[T]he greatest threat posed by *Loper Bright* is cultural: the prospect of agencies overinterpreting the decision's gravity and deciding to not even attempt to protect American workers and families." JORDAN ASCHER, WILL DOBBS-ALLSOPP & RACHAEL KLARMAN, GOVERNING FOR IMPACT, GUIDANCE FOR POLICYMAKERS: THE POST-*CHEVRON* WORLD 10 (2024) (citing Loper Bright Enters. v. Raimondo, 144 S. Ct. 2244 (2024)), https://governingforimpact.org/wp-content/uploads/2024/08/The-Post-Chevron-World_-Guidance-for-Policymakers_August2024.pdf [https://perma.cc/4E4T-DMBK].

[35] *See Loper Bright*, 144 S. Ct. at 2269–70, 2273 (overturning 40 years of precedent requiring courts to defer to agencies in certain circumstances); West Virginia v. EPA, 142 S. Ct. 2587, 2608–10 (2022) (deciding the most significant major questions doctrine case in recent years).

[36] Andrew Chung, *US Supreme Court's Conservatives Flex Muscles to Curb Regulatory Agencies*, REUTERS (July 1, 2024, at 13:52 PDT), https://www.reuters.com/legal/us-supreme-courts-conservatives-flex-muscles-curb-regulatory-agencies-2024-06-30/ (on file with the Lewis & Clark Law Review).

[37] *See* sources cited *supra* note 35 and accompanying text.

(HRSA), that grant HHS the authority to undertake rulemaking, guidance, and oversight and enforcement actions which can advance birth justice.

There are missed opportunities to advance birth justice. Specifically, this Article highlights how the federal government has allowed and perpetuated birth injustices and it offers policy recommendations to move forward. The policy recommendations offered include enforcing the ACA nondiscrimination provision to hold providers and health systems accountable; administering the Medicaid and Medicare conditions of participation to incentivize respectful, nondiscriminatory maternity care; developing payment and delivery models that tie federal payment to quality; issuing grants under the HRSA's maternal health programs to expand the perinatal workforce; creating a federal minimum network adequacy standard to improve choice in birthing support; creating a federal minimum standard for plans subject to the ACA Essential Health Benefit requirement; and investing in equity-driven research and analysis. The breadth of the examples illustrate that agencies still have significant flexibilities that can be exercised.

In contrast, this Article also highlights the various ways the federal government is currently undermining or threatening maternal health care access, quality, and ultimately outcomes. This includes undermining programs focused on expanding the perinatal workforce, eliminating access to trusted providers offering preconception care and family planning services, undermining coverage and access to maternal health services, eliminating staff overseeing maternal health programs, and undermining research on maternal health outcomes. Most importantly, the consistent and persistent targeting of any program associated with equity for people of color, women, people with disabilities, and LGBTQIA people, particularly transgender persons, represents a dire threat to maternal health that could cost lives.

In short, this Article uses the maternal health context to demonstrate how the dismantling of the federal government impacts people's health and well-being. Further, the Article also adds to the legal literature because it assesses the recent Supreme Court decisions on agency deference to outline how regulators and advocates can navigate the current legal landscape in the pursuit toward birth justice. While the focus here is birth justice, this Article's roadmap can serve as an example for health justice more broadly, as well as other issues.

Part I aims to situate the analysis and explains the "why" for regulating to advance birth justice. This Part offers a working definition of birth justice to outline the ultimate goals for maternal health and assesses the state of U.S. maternal health care considering these goals. Part II considers the "what" and explains the value federal agencies can add to addressing the maternal health crisis, including missed opportunities to advance birthing people's well-being. This Part engages in a statutory analysis to explain the legal authorities for HHS to act, and it offers specific policy recommendations. Finally, this Part documents the policies HHS has implemented moving in the exact opposite direction of those recommendations. Part III primarily considers "how" to regulate towards birth justice. This Part

explains the obstacles to advancing meaningful administrative actions and it applies the recent jurisprudence to the policy recommendations offered to discern a path forward.

I. SITUATING BIRTH INJUSTICES

There is a burgeoning birth justice movement that has gained momentum in recent years.[38] Birth justice advocates have recognized the need for a movement that focuses on pregnancy and childbirth.[39] This movement has grown out of the reproductive justice movement and theory, and therefore builds upon many of the principles that reproductive justice scholars have long touted.[40] Birth justice as a movement is a nascent movement that has largely developed over the past 15 years.[41] Notably, birth justice, unlike reproductive justice, does not have a commonly understood definition.[42] To establish a standard that the law and policy should be aiming to achieve, I highlight below advocates' stated intentions for birth justice and begin to offer my view of its core tenants. Section I.A outlines birth justice principles, and Section I.B assesses the current state of maternal health considering these principles.

---

[38] *See, e.g.*, *Birth Justice: Our Model*, ELEPHANT CIRCLE, https://www.elephantcircle.net/our-model [https://perma.cc/8HGK-RETK] (last visited Dec. 30, 2025) (outlining the advocacy model and advocacy work done by the Elephant Circle group regarding birth justice).

[39] *See generally* BIRTHING JUSTICE: BLACK WOMEN, PREGNANCY, AND CHILDBIRTH (Alicia D. Bonaparte & Julia Chinyere Oparah eds., 2d ed. 2024) (collecting essays recounting Black women's agency in the birth justice movement).

[40] LORETTA J. ROSS & RICKIE SOLINGER, REPRODUCTIVE JUSTICE: AN INTRODUCTION 96 (2017).

[41] BIRTHING JUSTICE: BLACK WOMEN, PREGNANCY, AND CHILDBIRTH, *supra* note 39, at 6–7.

[42] *See, e.g.*, *What We Believe: Birth Justice Framework*, *supra* note 20 ("Birth Justice includes the right to choose whether or not to carry a pregnancy, to choose when, where[,] how, and with whom to birth, including access to traditional and indigenous healers, such as midwives and other birth workers, and the right to breastfeeding support."); *What Is Birth Justice*, VOICES FOR BIRTH JUST., https://voicesforbirthjustice.org/birth-justice/ [https://perma.cc/D2H3-5JW7] (last visited Dec. 30, 2025) ("Birth Justice is a movement that believes when birthing people recognize their innate power to make the best health decisions for themselves and their families during all stages of the pregnancy, birth, and the post-birth period, that power will have a transformational impact on their family and community."); *Birth Justice*, ADVANCING NEW STANDARDS IN REPROD. HEALTH, https://www.ansirh.org/pregnancy/birth-justice [https://perma.cc/5XC6-ZA28] (last visited Dec. 30, 2025) ("Birth justice is a movement led by Black women and women of color that seeks to recognize those inequalities and to empower people in these communities in the pregnancy and birthing process. The birth justice movement works to safeguard the rights of birthing people to make decisions around their pregnancies, including seeking abortions, and to have children in safe and supportive environments."); *Birth Justice Initiative*, HORIZON FOUND.: BIRTH JUST., https://www.thehorizonfoundation.org/birth-justice/ [https://perma.cc/9F3M-RH6N] (last visited Dec. 30, 2025) ("Birth justice ensures all birthing people get quality, respectful care and have a say in their own birthing journey.").

Finally, Section I.C offers a brief historical account that informed the present state of laws influencing maternal health. This Section considers how state actors, including the federal government, have tolerated, perpetuated, and even created maternal health inequities. Specifically, maternal health inequities can be traced to who the government has deemed "worthy" to be a mother.

A. Birth Justice Principles

The chief aim for birth justice is to empower birthing people to have the birthing experiences they choose; maintain dignity and respect in the prenatal, labor, and postpartum periods; and ultimately, to have positive health outcomes.[43] More is demanded than preventing maternal deaths and morbidity. Achieving birth justice requires empowering all birthing people with the information and resources needed for them to make autonomous decisions regarding their childbirth.[44]

Jamarah Amani, a community midwife and Executive Director of Southern Birth Justice Network, is described as the "architect of the Black Midwives Model of Care and the Birth Justice Bill of Rights."[45] In describing its "Birth Justice Framework," Southern Birth Justice's website explains:

> Birth Justice includes access to health care during the childbearing year that is holistic, humanistic, and culturally centered. This health care is across the pregnancy spectrum including: abortion, miscarriage, prenatal, birth, and postpartum care. Birth Justice includes the right to choose whether or not to carry a pregnancy, to choose when, where[,] how, and with whom to birth, including access to traditional and indigenous healers, such as midwives and other birth workers, and the right to breastfeeding support. The complete range of pregnancy, labor, and birth options should be available to everyone as an integral part of reproductive justice. These are our rights as mothers and parents.[46]

Legal advocates, Farah Diaz-Tello and Lynn Paltrow, offer one of the most expansive definitions of birth justice found in the legal literature:

> [Birth justice] is, at a minimum, having access to evidence-based maternity care, accurate information about pregnancy, the risks and benefits of medical

---

[43] ROSS & SOLINGER, *supra* note 40, at 96, 188.

[44] Farah Diaz-Tello & Lynn Paltrow, *NAPW Working Paper: Birth Justice as Reproductive Justice* 1 (May 2012) (unpublished manuscript) (on file with National Advocates for Pregnant Women); *see* Aly McKnight, Note, *The Human Rights Approach to Address Black Maternal Mortality: Why Policymakers Should Listen to Black Moms*, 14 NE. U. L. REV 679, 711–13 (2022) (concluding that impacted community perspectives should be prioritized to address the maternal health crisis).

[45] *Our Team: Staff*, S. BIRTH JUST. NETWORK, https://southernbirthjustice.org/our-team [https://perma.cc/N56S-HRHD] (last visited Dec. 30, 2025).

[46] *What We Believe: Birth Justice Framework*, *supra* note 20.

> procedures, and the agency to choose whether or not to undergo those medical procedures. It is having the power to make those choices and give birth free from fear of intimidation or interference from outsiders [due] to "noncompliance" with medical advice, or because of poverty, race or ethnicity, or immigrant status. It is also having access to culturally respectful labor support.
>
> Birth justice is ensuring that no aspect of pregnant women's decision making is minimized or belittled.[47]

In short, birth justice requires freedom to make one's health care decisions—even while pregnant.

A birth justice framework should center the woman or birthing person.[48] Too often a woman's well-being—if she is considered at all—is only secondary to a fetus and infant.[49] A healthy mother and pregnancy often lead to a healthy baby, and a fetus's and infant's health should be considered in medical practice if the intent is to carry a pregnancy to term; however, the woman or birthing person should not be consistently secondary. Medical interventions performed on pregnant persons should require informed consent. More specifically, a healthy baby does not negate neglect, mistreatment, discrimination, or coercion experienced during childbirth, and it certainly does not negate maternal mortality, morbidity, "near misses," or other adverse health outcomes of the birthing person.

Birth justice, like reproductive justice before it, builds upon the intersectionality framework as created by legal scholar Kimberlé Crenshaw.[50] Birth justice cannot be achieved without considering the unique challenges, discrimination, and perspective each birthing person must navigate to have a healthy pregnancy and postpartum period. The combination of race, ethnicity, disability,

---

[47] Diaz-Tello & Paltrow, *supra* note 44, at 2–3.

[48] *See What We Believe: Birth Justice Framework*, *supra* note 20. Southern Birth Justice offers a birth justice "Bill of Rights" which includes a list of 22 rights including "care for all my identities," "access to everything I need to be healthy," and "inclusion in the decisions that affect me." *Id.*

[49] *See* Johanna Eichinger, Andrea Büchler, Louisa Arnold & Michael Rost, *Women's and Provider's Moral Reasoning About the Permissibility of Coercion in Birth: A Descriptive Ethics Study*, 32 HEALTH CARE ANALYSIS 184, 191–200 (2024) (documenting the reasoning often used to justify coercion in childbirth, including concern for the infant as paramount); *see also* Maria T.R. Borges, Note, *A Violent Birth: Reframing Coerced Procedures During Childbirth as Obstetric Violence*, 67 DUKE L.J. 827, 836–38 (2018) (discussing the negative consequences experienced by birthing women when denied their rights in favor of the fetus's, including the inability to recover any kinds of damages in any subsequent legal actions).

[50] ROSS & SOLINGER, *supra* note 40, at 73–78. *See generally* Kimberle Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics*, 1989 U. CHI. LEGAL F. 139 (1989) (using an intersectionality approach to analyze discrimination faced by Black women in America in comparison to less-marginalized groups).

immigration, socioeconomic status, religion, geographic locations, and other identity and circumstantial characteristics will result in different birthing experiences.[51] In particular, birth justice adopts a Critical Race Theory analysis to consider how the law has been used to discriminate and embed racism into health policies.[52] The goal is not to achieve equality in experiences given—this is not realistic or even desired in our multifaceted society. The goal should be to achieve equity in outcomes. Achieving birth justice, therefore, involves combating racism, sexism, homophobia, gender inequity, xenophobia, ableism, ageism, and classism in various U.S. systems.

Birth justice cannot be achieved by only addressing individual behaviors. It requires the medical establishment, the government, and the legal system to actively support these decisions. Reproductive justice, from its inception, has argued that the government has a positive obligation to ensure people can realize reproductive autonomy.[53] Birth justice, too, recognizes that people cannot have a meaningful choice in their birthing decisions without a government and society that not only remove barriers to decision making but provide structures to support those decisions.[54] Transforming legal and political structures is not the chief goal of reproductive justice, nor is it the primary goal of birth justice.[55] Even still, I offer that the law should be used as a tool to accomplish the wishes and desires of birthing people and their communities.

B. Assessing the Problem

The United States is far from achieving birth justice. The United States has the worst maternal health outcomes among developed nations despite spending more on health care.[56] While a common image of maternal death has been death during

---

[51] *See* ROSS & SOLINGER, *supra* note 40, at 74–75.

[52] *See* Khiara M. Bridges, Terence Keel & Osagie K. Obasogie, *Introduction: Critical Race Theory and the Health Sciences*, 43 AM. J.L. & MED. 179, 179 (2017); Khiara M. Bridges, *Quasi-Colonial Bodies: An Analysis of the Reproductive Lives of Poor Black and Racially Subjugated Women*, 18 COLUM. J. GENDER & L. 609, 622 (2009) ("[T]he false promise of poor Black women's reproductive rights is not just a failure of the women's movement; it is a failure of racial justice.").

[53] ROSS & SOLINGER, *supra* note 40, at 12–17 (discussing the historical relationship between reproductive justice and the U.S. government, economy, politics, and more).

[54] *See What Is Birth Justice*, *supra* note 42 ("[R]eproductive justice was a direct response to the intersectional systems of power and oppression that often prevented the attainment of full health.").

[55] *See* ROSS & SOLINGER, *supra* note 40, at 69; *What Is Birth Justice*, *supra* note 42.

[56] Justina Petrullo, *US Has Highest Infant, Maternal Mortality Rates Despite the Most Health Care Spending*, AM. J. MANAGED CARE (Jan. 31, 2023) (citing Munira Z. Gunja, Evan D. Gumas & Reginald D. Williams II, *U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes*, COMMONWEALTH FUND (Jan. 31, 2023), https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-

delivery, in reality maternal deaths occur throughout the pregnancy and the postpartum period: About one-quarter of deaths occur during pregnancy and more than half of pregnancy-related deaths occur up to one year after the end of pregnancy.[57] Even more, the maternal health discussion frequently focuses on women who die, but it is also problematic that 50,000 to 60,000 women in the United States experience severe maternal morbidity annually.[58] The CDC defines severe maternal morbidity as "an unexpected outcome of labor and delivery that results in significant short- or long-term consequences to a woman's health."[59] Between 1993 and 2014, the overall rate of severe maternal morbidity increased 200% and continues to increase.[60]

Further, the CDC's definition of severe maternal morbidity includes only morbidities that result from childbirth, which means the rate does not account for morbidities resulting from prenatal and postpartum conditions.[61] Such prenatal

---

perspective-2022 [https://perma.cc/QC6Y-4724]), https://www.ajmc.com/view/us-has-highest-infant-maternal-mortality-rates-despite-the-most-health-care-spending [https://perma.cc/G7HT-T6FG].

[57] Press Release, Ctrs. for Disease Control & Prevention, *supra* note 18; EUGENE DECLERCQ & LAURIE ZEPHYRIN, COMMONWEALTH FUND, MATERNAL MORTALITY IN THE UNITED STATES: A PRIMER 3 (2020), https://www.commonwealthfund.org/sites/default/files/2020-12/Declercq_maternal_mortality_primer_db.pdf [https://perma.cc/9XF4-LQ6P] (distinguishing between pregnancy-associated mortality, pregnancy-related mortality, and the maternal mortality rate).

[58] EUGENE DECLERCQ & LAURIE ZEPHYRIN, COMMONWEALTH FUND, SEVERE MATERNAL MORBIDITY IN THE UNITED STATES: A PRIMER 1 (2021), https://www.commonwealthfund.org/sites/default/files/2021-10/Declercq_severe_maternal_morbidity_in_US_primer_db.pdf [https://perma.cc/QCN2-BQ3W]. *But see* Eugene R. Declercq, Howard J. Cabral, Xiaohui Cui, Chia-Ling Liu, Ndidiamaka Amutah-Onukagha et al., *Using Longitudinally Linked Data to Measure Severe Maternal Morbidity*, 139 OBSTETRICS & GYNECOLOGY 165, 169–70 (2022) (finding that the national maternal morbidity rate could be closer to 90,000 women annually—even more severe than thought before).

[59] *Severe Maternal Morbidity*, CTRS. FOR DISEASE CONTROL & PREVENTION (May 15, 2024), https://www.cdc.gov/maternal-infant-health/php/severe-maternal-morbidity/index.html [https://perma.cc/L5WG-AKYR].

[60] Nicholas J. Somerville, Timothy C. Nielsen, Elizabeth Harvey, Sarah Rae Easter, Brian Bateman, Hafsatou Diop & Susan E. Manning, *Obstetric Comorbidity and Severe Maternal Morbidity Among Massachusetts Delivery Hospitalizations, 1998–2013*, 23 MATERNAL & CHILD HEALTH J. 1152, 1152 (2019) (citing *Severe Maternal Morbidity in the United States*, CTRS. FOR DISEASE CONTROL & PREVENTION (Nov. 27, 2017), https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html (on file with the Lewis & Clark Law Review)); Dorothy A. Fink, Deborah Kilday, Zhun Cao, Kelly Larson, Adrienne Smith et al., *Trends in Maternal Mortality and Severe Maternal Morbidity During Delivery-Related Hospitalizations in the United States, 2008 to 2021*, JAMA NETWORK, June 22, 2023, at 1, 13–15.

[61] *See* DECLERCQ & ZEPHYRIN, *supra* note 58, at 1 ("Broadening the definition of severe maternal morbidity to also encompass serious illnesses during pregnancy and postpartum reveals the broader scope of the problem as well as the need for further measurement efforts and policy intervention.").

conditions include, but are not limited to, miscarriage, prenatal hypertension, depression and anxiety, preeclampsia, ectopic pregnancy, and hyperemesis gravidarum.[62] Postpartum conditions can include depression, endometritis, post-traumatic stress disorder, hemorrhage, heart failure, and sepsis.[63] These rates also do not fully capture "near misses"—episodes which could have resulted in death but were narrowly averted—and other complications that people might experience during pregnancy and within the first year postpartum.[64]

Statistics also cannot adequately account for the discrimination, mistreatment, disrespect, and coercion that many women and birthing people report experiencing during pregnancy, labor, and the postpartum period. There are reports of birthing people being pressured into cesarean section (C-section) surgeries, including during active labor.[65] It is common for a person in labor to be given Pitocin, a medication to induce labor, and there are reports of this being done without adequate information that the birth could safely progress naturally.[66] Women's concerns are frequently dismissed in the health care system, and women of color, young women, women with low incomes, and women with disabilities are the most likely to report feeling unheard or report a negative experience with healthcare professionals.[67] In addition to the direct adverse health risks associated with these medical

---

[62] *Id.* at 4.

[63] *Id.*

[64] *Id.* at 1.

[65] *E.g.*, Kukura, *supra* note 12, at 731–32; Amnesty International, *supra* note 14, at 78 (discussing the risks of C-sections and the "significant variation from hospital to hospital" in C-section guidelines); Saraswathi Vedam, Kathrin Stoll, Tanya Khemet Taiwo, Nicholas Rubashkin, Melissa Cheyney et al., *The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States*, REPROD. HEALTH, June 11, 2019, at 1, 14.

[66] *Pitocin Induction During Labor*, BIRTH INJ. HELP CTR., https://www.birthinjuryhelpcenter.org/birth-injuries/delivery-complications/pitocin-oxytocin/pitocin-faq/ [https://perma.cc/V2T3-UKD7] (last visited Jan. 2, 2026).

[67] CARY FUNK, PEW RSCH. CTR., BLACK AMERICANS' VIEWS OF AND ENGAGEMENT WITH SCIENCE 51 (2022), https://www.pewresearch.org/wp-content/uploads/sites/20/2022/04/PS_2022.04.07_Black-Americans-and-science_REPORT.pdf [https://perma.cc/6EHG-GXRV] (finding 71% of Black women 18 to 49 years old and 54% of Black women age 50 and older reported a negative experience with a health care provider); Michelle Long, Brittni Frederiksen, Usha Ranji, Karen Diep & Alina Salganicoff, *Women's Experiences with Provider Communication and Interactions in Health Care Settings: Findings from the 2022 KFF Women's Health Survey*, KFF (Feb. 22, 2023), https://www.kff.org/womens-health-policy/issue-brief/womens-experiences-with-provider-communication-interactions-health-care-settings-findings-from-2022-kff-womens-health-survey/ [https://perma.cc/G7PV-4JPL] (finding that within the past two years, 46% of women aged 18–35 had a negative interaction with a provider during a clinical visit, including having their health concerns dismissed, being blamed for health problems, or experiencing discrimination, among other negative interactions; 45% of low-income women and 45% of women with a disability or ongoing health condition experienced negative interactions with providers during clinical visits).

interventions, coercing a person into an unwanted, unnecessary procedure can increase a pregnant person's anxiety level, particularly given this is often the most extensive encounter healthy women of reproductive age have with the healthcare system.[68] Overall, such mistreatment naturally decreases overall enjoyment during what might be a joyous occasion. These occurrences are hard to measure with concrete numbers, but it is safe to assume that even the anecdotal stories shared are only a sample of what is occurring. The overturning of *Roe v. Wade*, and the subsequent state bans on abortion are likely to worsen maternal health outcomes.[69] States with abortion bans tend to have higher maternal mortality and morbidity rates. Those who are denied wanted abortions are more likely to have worse maternal and infant health outcomes.[70]

All women and pregnant people can experience maternal mortality and morbidity; however, the disparities are most starkly felt among Black and Indigenous women.[71] Specifically, Black and Native American women are around three times more likely to die from pregnancy-related complications and are two times more likely to experience severe maternal morbidity compared to non-Hispanic whites.[72] The maternal death rate among Latina women is comparable to non-Hispanic white women;[73] however, the overall rate among Latinos masks the high death rate among certain communities such as Puerto Ricans.[74]

Numerous studies have concluded that racism is an underlying cause for the disparities in maternal mortality and morbidity.[75] Even when controlling for the usual predictive factors—education and income—Black and Indigenous women

---

[68] *See* Diaz-Tello & Paltrow, *supra* note 44, at 4–5.

[69] *See* Roe v. Wade, 410 U.S. 113, 164–65 (1973), *overruled by*, Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022).

[70] *See* GENDER EQUITY POL'Y INST., MATERNAL MORTALITY IN THE UNITED STATES AFTER ABORTION BANS: MOTHERS LIVING IN ABORTION BAN STATES AT SIGNIFICANTLY HIGHER RISK OF DEATH DURING PREGNANCY AND CHILDBIRTH 1–4 (2025), https://zenodo.org/records/14713213/files/GEPI-maternal-mortality-abortion-bans.pdf?download=1 [https://perma.cc/BEP5-Q3D4].

[71] Hill et al., *supra* note 11.

[72] *Id.*; Ailish Burns, Teresa DeAtley & Susan E. Short, *The Maternal Health of American Indian and Alaska Native People: A Scoping Review*, SOC. SCI. & MED., Jan. 2023, at 1, 1–2.

[73] Hill et al., *supra* note 11.

[74] Wilda Parker-Collins, Fanny Njie, David A. Goodman, Shanna Cox, Jeani Chang et al., *Pregnancy-Related Deaths by Hispanic Origin, United States, 2009–2018*, 32 J. WOMEN'S HEALTH 1320, 1325 (2023) ("People of Puerto Rican origin had higher pregnancy-related mortality ratio point estimates across all known education levels compared with other Hispanic origins of equivalent education."); *see* Barbara Gutierrez, *Puerto Rican Birth Outcomes Spark Concern*, UNIV. MIA. NEWS (Sep. 10, 2024), https://news.miami.edu/stories/2024/09/puerto-rican-birth-outcomes-spark-concern.html [https://perma.cc/Y3BC-775A].

[75] *See, e.g.*, Hill et al., *supra* note 11 (providing an overview of findings related to maternal health and discussing the factors that drive the disparities and recent efforts to address them).

still have worse outcomes.[76] To put a finer point on it, a Black woman with a college education is more likely to die from maternal mortality than a white woman with a high school degree.[77] To be clear, it is not the race of birthing and pregnant people driving these inequities, but individual and structural racism that is leading to preventable deaths and morbidity.[78] Poor maternal health outcomes, including maternal deaths, are the symptoms of disrespect, mistreatment, and coercion.[79]

In addition to race and ethnicity, there are other maternal health disparities. People living in rural communities are more likely than those living in urban centers to experience maternal mortality or morbidity.[80] Similarly, people with intellectual, developmental, and physical disabilities often have higher maternal mortality rates.[81] People with disabilities are also more likely to experience infections, hemorrhaging, hypertension, preeclampsia, and risk factors associated with cardiovascular disease.[82] The maternal mortality rate also increases significantly with age—women over 40 years old are nearly seven times more likely to die from pregnancy compared to women under age 25.[83]

In sum, women and birthing people in the United States experience preventable adverse maternal health outcomes and experiences. Birthing people do not have the information and resources needed to make autonomous decisions regarding their childbirth, and subsequently, women and birthing people are being

[76] *Id.*

[77] *Id.*

[78] *See id.*; *Systemic Racism, a Key Risk Factor for Maternal Death and Illness*, NAT'L INSTS. OF HEALTH (Apr. 26, 2021), https://www.nhlbi.nih.gov/news/2021/systemic-racism-key-risk-factor-maternal-death-and-illness (on file with the Lewis & Clark Law Review).

[79] *See* Yousra A. Mohamoud, Elizabeth Cassidy, Erika Fuchs, Lindsay S. Womack, Lisa Romero et al., *Vital Signs: Maternity Care Experiences—United States, April 2023*, 72 MORBIDITY & MORTALITY WKLY. REP. 961, 962–63 (2023).

[80] Katharine A. Harrington, Natalie A. Cameron, Kasen Culler, William A. Grobman & Sadiya S. Khan, *Rural–Urban Disparities in Adverse Maternal Outcomes in the United States, 2016–2019*, 113 AM. J. PUB. HEALTH 224, 224 (2023) (concluding that people living in a rural area are 9% more likely than people living in urban areas to experience maternal mortality and morbidity).

[81] Monika Mitra, Ilhom Akobirshoev, Anne Valentine, Hilary K. Brown & Tiffany Moore Simas, *Severe Maternal Morbidity and Maternal Mortality in Women with Intellectual and Developmental Disabilities*, 61 AM. J. PREVENTATIVE MED. 872, 879 (2021); Jessica L. Gleason, Jagteshwar Grewal, Zhen Chen, Alison N. Cernich & Katherine L. Grantz, *Risk of Adverse Maternal Outcomes in Pregnant Women with Disabilities*, JAMA NETWORK, Dec. 15, 2021, at 1, 7–9; *NIH Study Suggests Women with Disabilities Have Higher Risk of Birth Complications and Death*, NAT'L INSTS. OF HEALTH (Dec. 15, 2021), https://www.nih.gov/news-events/news-releases/nih-study-suggests-women-disabilities-have-higher-risk-birth-complications-death/ [https://perma.cc/94MN-NV3T].

[82] Caroline Signore, Maurice Davis, Candace M. Tingen & Alison N. Cernich, *The Intersection of Disability and Pregnancy: Risks for Maternal Morbidity and Mortality*, 30 J. WOMEN'S HEALTH 147, 149–51 (2021).

[83] HOYERT, *supra* note 11, at 1.

directly and indirectly coerced into receiving undesired procedures and services. Even worse, the health inequities are leading to preventable deaths and unwanted experiences. The health outcomes for Black and Indigenous women alone will prevent the United States from even approaching birth justice. The current state of maternal health care access and outcomes is a national failure.

C. The System Was Built Inequitable

Government systems have historically discouraged women of color, low-income women, women with disabilities, immigrant women, and nonbinary people from becoming mothers. This history has informed laws, policies and practices and continues into the present. Today, these same communities have the highest maternal health disparities. Even more, the government, at all levels and branches, has failed to respond to these inequities. At the federal level, Congress has not had the political will to advance comprehensive health reform legislation that tackles structural racism and other systemic failures contributing to maternal health inequities. Federal courts continuously prioritize rights of fetuses over rights of women and birthing people. Federal agencies have also funded and promoted practices that diminish pregnant people's autonomy, and still other practices that are outright coercive.

Women's decisions about when, where, and with whom to become pregnant and have a child have not been supported in the United States. Black women, in particular, have historically been, and currently are, denied autonomy in birthing decisions. Enslavers benefited from Black women giving birth to other human beings who could be held captive, be subjected to hard labor, and generate profits.[84] This meant these women often did not get to choose the partners with whom they procreated or when to become pregnant.[85] Long hours standing in the sun while planting or picking crops led to many pregnancies ending involuntarily.[86] The cruel, inhumane conditions of slavery led some enslaved women to terminate their pregnancies and a small number to commit infanticide.[87] Of course, enslaved women did not have the ability to parent their children freely on a plantation that was ruled by an owner, who often did not share their same culture, language,

---

[84] MARIE JENKINS SCHWARTZ, BORN IN BONDAGE: GROWING UP ENSLAVED IN THE ANTEBELLUM SOUTH 20–21 (2000).

[85] Aisha Djelid, *"The Master Whished to Reproduce": Slavery, Forced Intimacy, and Enslavers' Interference in Sexual Relationships in the Antebellum South, 1808–1861*, 25 AM. NINETEENTH CENTURY HIST. 21, 25 (2024).

[86] Deirdre Cooper Owens & Sharla M. Fett, *Black Maternal and Infant Health: Historical Legacies of Slavery*, 109 AM. J. PUB. HEALTH 1342, 1343 (2019).

[87] *See* Emily West & Erin Shearer, *Fertility Control, Shared Nurturing, and Dual Exploitation: The Lives of Enslaved Mothers in the Antebellum United States*, 27 WOMEN'S HIST. REV. 1006, 1009–10 (2018).

spiritual practices, or beliefs.[88] Enslaved women also lived with the reality that their romantic partners, children, or they themselves could be sold and separated from one another.[89]

Even more, these women were used as tools to advance white women's maternal and reproductive health. J. Marion Sims, credited as a "father of gynecology," experimented upon enslaved Black women frequently without anesthesia.[90] François Marie Prevost, another early gynecologist, performed repeated experiments on enslaved women to pioneer C-sections.[91] While enslaved women were often not given time out of the field to nurse their own children, they were frequently required to breastfeed white women's children.[92]

Once Black children were no longer seen as profitable commodities for white slave owners, society and the government began to discourage—and even actively sought to prevent—Black women from becoming mothers. Illustratively, over 50,000 Black southern women were sterilized in the 1960s and 1970s without their informed consent.[93] These forced sterilizations were frequently paid for with federal funding.[94] The systemic government erasure of Native Americans was aided by policies inhibiting Indigenous women from reproducing autonomously.[95] The forced removal of Indigenous people from their ancestral lands caused many pregnant women and their children to die as they were forced to walk West.[96] The government, as well as religious missionaries, sought to turn Native women into "good Christian mothers" and to "civilize" them into adopting European

---

[88] R. J. Knight, *Mistresses, Motherhood, and Maternal Exploitation in the Antebellum South*, 27 WOMEN'S HIST. REV. 990, 992–93, 997 (2018).

[89] *See* Djelid, *supra* note 85, at 25.

[90] Camila Domonoske, *'Father of Gynecology,' Who Experimented on Slaves, No Longer on Pedestal in NYC*, NPR: THE TWO WAY (Apr. 17, 2018, at 13:39 ET), https://www.npr.org/sections/thetwo-way/2018/04/17/603163394/-father-of-gynecology-who-experimented-on-slaves-no-longer-on-pedestal-in-nyc [https://perma.cc/AB38-WRBK]; *see* Owens & Fett, *supra* note 86, at 1343.

[91] Owens & Fett, *supra* note 86, at 1343.

[92] ANDREA FREEMAN, SKIMMED: BREASTFEEDING, RACE, AND INJUSTICE 38–39 (2020).

[93] DOROTHY ROBERTS, KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY 93 (1997).

[94] *See* Relf v. Weinberger, 372 F. Supp. 1196, 1198–99 (D.D.C. 1974), *vacated as moot*, 565 F.2d 722 (D.C. Cir. 1977) (challenging federal regulations after low-income persons were involuntarily sterilized through a family planning program, exposing wide-spread sterilization abuse in federally-funded health clinics).

[95] *See* BRIANNA THEOBALD, REPRODUCTION ON THE RESERVATION: PREGNANCY, CHILDBIRTH, AND COLONIALISM IN THE LONG TWENTIETH CENTURY 35–38 (2019).

[96] *See* Nat'l Insts. of Health & Nat'l Libr. of Med., *1838: Cherokee Die on Trail of Tears*, NATIVE VOICES: NATIVE PEOPLES' CONCEPTS OF HEALTH & ILLNESS, https://www.nlm.nih.gov/nativevoices/timeline/296.html [https://perma.cc/BD7B-X2FU] (last visited Jan. 5, 2026).

practices.[97] Children were often forcibly removed from the home, and those who refused were often sent to boarding schools with Christian affiliations.[98] The Indian Health Service has been accused of sterilizing at least 25%, but estimated to be as many as 45%, of the Native American women of reproductive age during the 1970s.[99] The government also punished Native women living on reservations for giving birth out of wedlock.[100]

Low-income women have also faced policies that discourage them from becoming pregnant. In 1927, in *Buck v. Bell*, the Supreme Court upheld Virginia's forced sterilization of a young, poor woman who the state perceived as having an intellectual disability, and this ruling has never been overturned.[101] States have similarly enacted laws permitting sterilizations of people convicted of crimes and those considered "degenerate."[102] Judges have offered women and men lighter prison sentences in exchange for being sterilized, or for adopting an intrauterine device (IUD) or implant.[103] Given people with low incomes and people of color are more likely to be incarcerated, these practices disproportionately burden these communities.[104] As Angela Davis wrote in 1981: "More and more, it was assumed within birth control circles that poor women, Black and immigrant alike, had a 'moral obligation to restrict the size of their families.' What was demanded as a 'right' for the privileged came to be interpreted as a 'duty' for the poor."[105]

---

[97] *See* Brianna Theobald, *Settler Colonialism, Native American Motherhood, and the Politics of Terminating Pregnancies*, *in* TRANSCENDING BORDERS: ABORTION IN THE PAST AND PRESENT 221, 222–24, 228 (Shannon Stettner, Katrina Ackerman, Kristin Burnett & Travis Hay eds., 2017).

[98] Andrea Smith, *Boarding School Abuses, Human Rights, and Reparations*, 31 SOC. JUST., no. 4, 2004, at 89, 89.

[99] Micalea Simpson, Comment, *The Marshall Factor: How Forced Sterilization of Native American Women Birthed Generational Reproductive Injustice*, 49 S.U. L. REV. 65, 78, 81 (2021); Sophia Shepherd, *The Enemy Is the Knife: Native Americans, Medical Genocide, and the Prohibition of Nonconsensual Sterilizations*, 27 MICH. J. RACE & L. 89, 90, 100–01 (2021).

[100] *See* THEOBALD, *supra* note 95, at 104–07.

[101] Buck v. Bell, 274 U.S. 200, 205–08 (1927); *see also* Maura McIntyre, Note, Buck v. Bell *and Beyond: A Revisited Standard to Evaluate the Best Interests of the Mentally Disabled in the Sterilization Context*, 2007 U. ILL. L. REV. 1303, 1303–04, 1307–08 (2007) (analyzing the legal landscape since *Buck v. Bell* and discussing the policy concerns surrounding the sterilization of mentally disabled women).

[102] *See* ROSS & SOLINGER, *supra* note 40, at 30–31, 34.

[103] ROBERTS, *supra* note 93, at 200–01; Elise B. Adams, *Voluntary Sterilization of Inmates for Reduced Prison Sentences*, 26 DUKE J. GENDER L. & POL'Y 23, 30 (2018).

[104] *See* Aaron Gottlieb, *Incarceration and Relative Poverty in Cross-National Perspective: The Moderating Roles of Female Employment and the Welfare State*, 91 SOC. SERV. REV. 293, 295–97 (2017).

[105] ANGELA Y. DAVIS, WOMEN, RACE & CLASS 210 (Vintage Books 1983) (footnote omitted) (quoting LINDA GORDON, WOMAN'S BODY, WOMAN'S RIGHT: A SOCIAL HISTORY OF BIRTH CONTROL IN AMERICA 158 (1976)).

Paternalism has been embedded into the U.S. healthcare system and the state actors that support and regulate this system.[106] Illustratively, Black patients have historically been perceived as not intelligent enough to follow medical advice and as needing the healthcare system to act in their best interest.[107] Take the case of the Relf sisters, 12- and 14-year-old sisters who were sterilized without their or their mother's consent in the 1970s at a federal government-run clinic.[108] The clinic staff justified forcibly sterilizing these young women "because the girls were not 'disciplined' enough to take daily birth-control pills."[109] Birthing decisions have also been systematically controlled. After the male-dominated physician practices began to professionalize, traditional community birthing practices, which were often led by female midwives, were discouraged, painted as quackery, and outlawed.[110]

To be clear, these are not solely problems of the past. For example, in 2018, it was reported that a doctor had removed—without consent—the fallopian tubes of women in Immigration and Customs Enforcement (ICE) detention.[111] In only 2014, California banned coerced sterilizations for birth control in its prison system following the release of the documentary film *Belly of the Beast*, highlighting nearly 1,400 sterilizations performed between 1997 and 2013.[112] At least some of the women, mostly Black and Latina, claim these surgeries were performed without their

---

[106] *See* William K. Cody, *Paternalism in Nursing and Healthcare: Central Issues and Their Relation to Theory*, 16 NURSING SCI. Q. 288, 289 (2003).

[107] HARRIET A. WASHINGTON, MEDICAL APARTHEID: THE DARK HISTORY OF MEDICAL EXPERIMENTATION ON BLACK AMERICANS FROM COLONIAL TIMES TO THE PRESENT 15–16 (2006); Alice Abrokwa, *Too Stubborn to Care for: The Impacts of Discrimination on Patient Noncompliance*, 77 VAND. L. REV. 461, 478–79 (2024).

[108] Relf v. Weinberger, 372 F. Supp. 1196, 1198–99, 1200–01 (D.D.C. 1974), *vacated as moot*, 565 F.2d 722 (D.C. Cir. 1977); Complaint at 7–10, *Relf*, 372 F. Supp. 1196 (No. 73-1557).

[109] Linda Villarosa, *The Long Shadow of Eugenics in America*, N.Y. TIMES MAG. (June 8, 2022), https://www.nytimes.com/2022/06/08/magazine/eugenics-movement-america.html [https://perma.cc/GHZ9-T8NH] (detailing statements made by the director of the Montgomery family-planning clinic).

[110] *See, e.g.*, Charles Edward Ziegler, *The Elimination of the Midwife*, 60 JAMA 32, 32–38 (1913) ("I am, therefore, unalterably and uncompromisingly opposed to any plan which seeks to give [midwives] a permanent place in the practice of medicine. In no other branch of medicine do we permit ignorant, non-medical individuals to give counsel and assistance in medical matters. Midwifery is the most poorly done of all medical work, not alone because about 50[%] of all labors are in the hands of midwives, but largely because of the low standards of midwifery existent among physicians and laity alike.").

[111] Joe Penney, *Pauline Binam Says She Never Gave ICE Doctor Consent to Remove Her Fallopian Tube*, THE INTERCEPT (Oct. 2, 2020, at 12:56 PT), https://theintercept.com/2020/10/02/ice-irwin-amin-obgyn-cameroon-women/ [https://perma.cc/6GV7-YSE4].

[112] Shilpa Jindia, *Belly of the Beast: California's Dark History of Forced Sterilizations*, THE GUARDIAN (June 30, 2020, at 06:00 EDT), https://www.theguardian.com/us-news/2020/jun/30/california-prisons-forced-sterilizations-belly-beast [https://perma.cc/T9LX-UQVQ].

consent. While forced sterilization laws have been repealed, *Buck*'s legacy has impacted reproductive health policies that people with disabilities are subject to currently.[113] Contraceptive coverage in the Medicare program, which provides insurance coverage to certain people with disabilities, is generally more limited than other federal health programs—an omission that can limit the disability community's reproductive autonomy.[114] Following the Food and Drug Administration (FDA) approval of the first hormonal intrauterine device in 2000, some state Medicaid programs adopted policies to pay for the insertion of long-acting reversible contraceptives (LARCs) while denying reimbursement for removal of the same.[115] Providers have also encouraged LARCs at the exclusion of offering the full range of contraceptives.[116] Both practices

---

[113] Alessandra Suuberg, Buck v. Bell*, American Eugenics, and the Bad Man Test: Putting Limits on Newgenics in the 21st Century*, 38 L. & INEQ. 115, 122–24, 126–31 (2020); *see also* Jasmine E. Harris, *Why* Buck v. Bell *Still Matters*, PETRIE-FLOM CTR.: BILL OF HEALTH (Oct. 14, 2020), https://blog.petrieflom.law.harvard.edu/2020/10/14/why-buck-v-bell-still-matters [https://perma.cc/ST6Y-ADHA] ("*Buck's* lasting power lies not in its doctrinal deployment, but in its *expressive value* and how it continues to shape public norms and legal interpretations about the humanity and dignity of Black, Latinx, Indigenous, and disabled bodies and minds.").

[114] Meredith Freed, Juliette Cubanski, Michelle Long, Nancy Ochieng & Alina Salganicoff, *Coverage of Sexual and Reproductive Health Services in Medicare*, KFF (Apr. 30, 2024), https://www.kff.org/medicare/issue-brief/coverage-of-sexual-and-reproductive-health-services-in-medicare/ [https://perma.cc/2H2P-2RGE]; *see also* M. Antonia Biggs, Rosalyn Schroeder, M. Tara Casebolt, Bianca I. Laureano, Robin L. Wilson-Beattie et al., *Access to Reproductive Health Services Among People With Disabilities*, JAMA NETWORK, Nov. 29, 2023, at 1, 11 (showing disparities in access to reproductive care for people assigned female at birth with disabilities).

[115] DONNA SHOUPE, CONTRACEPTION & REPROD. MED., LARC METHODS: ENTERING A NEW AGE OF CONTRACEPTION AND REPRODUCTIVE HEALTH 2 (2016), https://pmc.ncbi.nlm.nih.gov/articles/PMC5675060/pdf/40834_2016_Article_11.pdf [https://perma.cc/5A5X-4NT9]. For instance, Pennsylvania only covers LARC removal every three years but covers insertion more frequently. This policy limits the ability of Medicaid beneficiaries to make autonomous decisions to remove a LARC. USHA RANJI, IVETTE GOMEZ & ALINA SALGANICOFF, KFF, MEDICAID COVERAGE OF FAMILY PLANNING BENEFITS: FINDINGS FROM A 2021 STATE SURVEY 10 (2022), https://files.kff.org/attachment/medicaid-coverage-of-family-planning-benefits-findings-from-a-2021-state-survey.pdf [https://perma.cc/2N6H-RT9Z]. Other states have previously paid for insertion but not removal. This practice was largely changed after advocates raised that this practice was coercive. Nat'l Women's Health Network & SisterSong, *Long-Acting Reversible Contraception Statement of Principles*, SISTERSONG (Aug. 14, 2025), https://health.usf.edu/publichealth/chiles/fpqc/larc/-/media/043402D6CF0842DD95DC65E6 04B07B46 [https://perma.cc/G2SV-E534]; *see also* Olivia Cappello, *Powerful Contraception, Complicated Programs: Preventing Coercive Promotion of Long-Acting Reversible Contraceptives*, 24 GUTTMACHER POL'Y REV. 36, 36–38 (2021) (discussing advocacy efforts which contributed to a "framework [that] provides policymakers a map for creating LARC programs").

[116] Victoria Boydell, Robert Dean Smith & Global LARC Collaborative, *Hidden in Plain Sight: A Systematic Review of Coercion and Long-Acting Reversible Contraceptive Methods (LARC)*, PLOS GLOB. PUB. HEALTH, Aug. 18, 2023, at 1, 11; *Opposing Coercion in Contraceptive Access and Care to Promote Reproductive Health Equity*, AM. PUB. HEALTH ASS'N (Oct. 25, 2021), https://apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2022/

were seemingly deployed to encourage low-income women to avoid pregnancy.

U.S. systems outside of healthcare have also operated to coerce birthing and reproductive decisions. Professor Dorothy Roberts explains that "[e]ugenicists opposed social programs designed to improve the living conditions of the poor."[117] Even before *Dobbs v. Jackson Women's Health Organization*,[118] law and anthropology scholar Khiara Bridges documented how low-income pregnant people were disenfranchised from the constitutional right to privacy as the state has justified surveilling their romantic relationships, eating and exercise habits, and employment history in exchange for medical care, food, and other government assistance.[119] Welfare policies have restricted financial assistance if a person has more than a state sanctioned number of children.[120] States have also used IQ tests to justify the termination of parental rights.[121] Relatedly, reproductive justice advocates, such as legal scholar Dorothy Roberts, have long highlighted that Black women, as well as low-income women, are more likely to have their children involuntarily placed in the child welfare system.[122] The concern that children will be placed into foster care is enough to make many mothers comply with medical orders.[123] Black and low-income communities are also

01/07/opposing-coercion-in-contraceptive-access-and-care-to-promote-reproductive-health-equity [https://perma.cc/7FFN-Z974].

[117] ROBERTS, *supra* note 93, at 65.

[118] 142 S. Ct. 2228, 2285 (2022) (overturning the decisions that rooted the right to abortion in the Constitution, thereby allowing states to regulate and prohibit abortion).

[119] *See* KHIARA M. BRIDGES, THE POVERTY OF PRIVACY RIGHTS 179–205 (2017); *see also* Debra A. DeBruin & Mary Faith Marshall, *Policing Women to Protect Fetuses: Coercive Interventions During Pregnancy*, *in* ANALYZING VIOLENCE AGAINST WOMEN 95, 95–96 (Wanda Teays ed., 2019) (considering assaults on self-determination, bodily integrity, and privacy inherent in interventions such as forced cesarean sections and criminal penalties for exposing fetuses to risk).

[120] *See* Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, § 103, 110 Stat. 2105, 2113–14, 2124 (containing a legislative package, colloquially known as welfare reform, generally limiting the cash assistance available to people with low incomes; this federal law allowed states to impose restrictions on the number of children for whom welfare recipients could receive cash assistance); *The Personal Responsibility and Work Opportunity Reconciliation Act of 1996*, U.S. DEP'T OF HEALTH & HUM. SERVS., OFF. OF THE ASSISTANT SEC'Y FOR PLANNING & EVALUATION (Aug. 31, 1996), https://aspe.hhs.gov/reports/personal-responsibility-work-opportunity-reconciliation-act-1996 [https://perma.cc/JZ79-VUMB].

[121] Britta Lokting, *The State Took These Children Away—Then Used Their Parents' Low IQ Scores to Keep Them Apart*, THE GUARDIAN (Mar. 6, 2024, at 10:00 EST), https://www.theguardian.com/us-news/2024/mar/06/parents-iq-test-child-welfare-oregon [https://perma.cc/9RVV-NJF7].

[122] *See, e.g.*, Dorothy E. Roberts, *Prison, Foster Care, and the Systemic Punishment of Black Mothers*, 59 UCLA L. REV. 1474, 1476–77 (2012).

[123] DeBruin & Marshall, *supra* note 119, at 95–97.

more likely to be targeted for criminalization during pregnancy.[124] A report from the nonprofit organization Pregnancy Justice found that in the time between the *Roe v. Wade* decision, which established the constitutional right to an abortion in 1973, and the *Dobbs* decision, which overturned the constitutional right to an abortion in 2022,[125] over 1,800 pregnant women had legal cases decided against them under the guise of protecting "unborn life."[126] Among these women, there were more arrests and convictions related to pregnancies that ended with birth or pregnancy loss than arrests and convictions related to abortion.[127] This demonstrates that pregnancy and childbirth can result in women and pregnant people not only losing their personal autonomy, but their personal and bodily freedom.

Courts have proven unwilling to respect birthing rights. Illustratively, the right to refuse medical treatment for one's own benefit is firmly settled, but courts have been willing to compel medical treatment of pregnant women under the guise of protecting fetal health.[128] For instance, in 1999, a federal district court in *Pemberton v. Tallahassee Memorial Center* concluded that a state court-ordered C-section did not violate privacy rights, even though the pregnant woman sought a vaginal delivery.[129] The court reasoned that "[t]he balance tips far more strongly in favor of the state in the case at bar, because here the full-term baby's birth was imminent, and more importantly, here the mother sought only to avoid a particular procedure for giving birth, not to avoid giving birth altogether."[130] According to the court, a woman seeking to deliver a child had "less" of an interest than both a woman seeking to terminate a pregnancy and the state.[131]

---

[124] PURVAJA S. KAVATTUR, SOMJEN FRAZER, ABBY EL-SHAFEI, KAYT TISKUS, LAURA LADERMAN ET AL., PREGNANCY JUST., THE RISE OF PREGNANCY CRIMINALIZATION: A PREGNANCY JUSTICE REPORT 2, 4 (2023), https://www.pregnancyjusticeus.org/wp-content/uploads/2023/09/9-2023-Criminalization-report.pdf [https://perma.cc/4VPS-EUHE].

[125] Roe v. Wade, 410 U.S. 113, 164–65 (1973) (recognizing a constitutional right to abortion), *overruled by*, Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022).

[126] KAVATTUR ET AL., *supra* note 124, at 3. The majority of the cases against pregnant people are related to allegations of ingesting drugs and alcohol. Notably, a quarter of cases involved the alleged use of legal substances, including prescription opiates, nicotine, and alcohol. *Id.* at 4.

[127] *Id.* at 24.

[128] *See* AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, COMM. ON ETHICS, OPINION NO. 664: REFUSAL OF MEDICALLY RECOMMENDED TREATMENT DURING PREGNANCY 4 (2016), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2016/06/refusal-of-medically-recommended-treatment-during-pregnancy.pdf [https://perma.cc/G29P-XE8T] (explaining that court-ordered interventions against pregnant women who refuse treatment are controversial and that this organization opposes the practice).

[129] *See* Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr., Inc., 66 F. Supp. 2d 1247, 1250–51, 1254 (N.D. Fla. 1999).

[130] *Id.* at 1251.

[131] *Id.* at 1251–52; *see also* Kukura, *supra* note 12, at 794–95 (discussing the *Pemberton* case).

Within recent years, Congress enacted laws aimed at improving maternal health outcomes, but these laws have not been the comprehensive reform needed. The Preventing Maternal Deaths Act, signed into law in 2018, tasks the CDC with supporting state and tribal maternal mortality and review committees in their efforts to collect and assess data on pregnancy-related deaths.[132] In 2018, Congress passed—with widespread bipartisan support—the Improving Access to Maternity Care Act, which requires the HRSA within HHS to identify maternal-health-professional shortage areas and to publish data comparing the need for maternity care health services.[133] While these laws demonstrate Congress' interest in maternal health, each of these laws focus on research and data collection—not actually addressing the underlying causes.[134] There has been expansive legislation introduced, across multiple Congresses, to address maternal health care inequities. The Black Maternal Health Momnibus Act of 2021 is a legislative package consisting of 12 bills that range in focus from health care delivery to climate change.[135] The only bill among this package that has been signed into law is a bill focused on veterans' health, an often politically palatable group.[136]

II. THE FEDERAL (GOVERNMENT) DETERMINANTS OF HEALTH

The federal government is uniquely positioned to address maternal health inequities. First, the federal government has contributed to and tolerated birth injustices, particularly for marginalized communities.[137] Therefore, it stands to reason that federal agencies are positioned to address these problems. Broadly, administrative law can and has been used as a tool to address systemic inequities,

---

[132] Preventing Maternal Deaths Act of 2018, Pub. L. No. 115-344, § 2, 132 Stat. 5047, 5048–49.

[133] Improving Access to Maternity Care Act, Pub. L. No. 115-320, § 2, 132 Stat. 4437, 4437 (2018); *All Actions: H.R.315—115th Congress (2017–2018)*, CONGRESS.GOV, https://www.congress.gov/bill/115th-congress/house-bill/315/all-actions (on file with the Lewis & Clark Law Review) (showing the unanimous voting in both the House and the Senate).

[134] *See* Khiara M. Bridges, *Racial Disparities in Maternal Mortality*, 95 N.Y.U. L. REV. 1229, 1286–89 (2020) (critiquing the Preventing Maternal Deaths Act for its focus on data collection while not mentioning the systemic racism that is known to underlie the problem).

[135] The Black Maternal Health Momnibus Act of 2021, H.R. 959, 117th Cong. (1st Sess. 2021).

[136] *See* Protecting Moms Who Served Act of 2021, Pub. L. No. 117-69, 135 Stat. 1495; *see also* Press Release, Off. of Lauren Underwood: 14th Dist. of Ill., President Biden Signs First Bill in Underwood's Historic 'Momnibus' Legislation into Law (Nov. 30, 2021), https://underwood.house.gov/media/press-releases/president-biden-signs-first-bill-underwoods-historic-momnibus-legislation-law [https://perma.cc/DV6W-LDAV] (celebrating the Protecting Moms Who Served Act as the "first bill of the Black Maternal Health Momnibus Act" signed into law).

[137] *See* discussion *supra* Section I.C.

including racial inequities. Legal scholar Vanessa Zboreak argues in *Regulatory Reparations* that administrative agencies have perpetuated and currently perpetuate racial injustices in this country, and thus, the same actors have a duty to address these injustices, including methodically considering these injustices in the regulatory process.[138] This is undoubtedly true in the context of maternal health.

Additionally, federal administrative agencies have the expertise and structure to address this ongoing, complex problem with tailored, granular policies. Congress has recognized the value of federal agency expertise on complex public health issues.[139] A select committee, tasked with examining Congress' structure, explains: "Historically, the bureaucracy, whether it be at the state or federal level, has led the way when it comes to implementing [evidence-based policymaking]."[140] Congress often intentionally enacts laws with directions to the federal government to fill in the policy details necessary to implement the laws. These "details" often require a depth of technical expertise that comes from agencies' ability to specialize in an issue area.[141] Specific to maternal health, Congress has authorized federal agencies to take actions to advance the health and well-being of people residing in the United States, including pregnant and birthing people.[142] Pursuant to these authorities, federal agencies across administrations have enacted policies recognizing their role in regulating maternal health care and coverage.

Section II.A explores the value-add federal agencies can bring to advancing birth justice and describes in detail the role HHS has had in regulating maternal health care. This Section summarizes statutes authorizing HHS to regulate maternal health care and outlines examples where federal regulations and policies have positively impacted maternal health care access and delivery. Consistent with the principles of birth justice, the analysis here focuses on six key areas: (1) oversight and accountability for discrimination; (2) incentives for high quality care; (3) investments into the perinatal workforce; (4) insurance provider network adequacy; (5) health insurance quality; and (6) research and evaluation. Within these same issue areas, Section II.B summarizes missed opportunities and describes

---

[138] Vanessa Zboreak, *Regulatory Reparations*, 14 ELON L.J. 215, 235–38 (2022) ("[A] system of regulatory reparations would situate much of that duty [to repair] in the administrative state itself, not as a means by which to repair the harms of past individual actors but the harms the administrative apparatus itself has inflicted.").

[139] *See, e.g.*, U.S. GOV'T ACCOUNTABILITY OFF., GAO-23-105460, EVIDENCE-BASED POLICYMAKING: PRACTICES TO HELP MANAGE AND ASSESS THE RESULTS OF FEDERAL EFFORTS 1 (2023) (discussing how federal law now includes "requirements for agencies to build and use different types of evidence to understand and improve results" of federal efforts).

[140] H.R. REP. NO. 117-646, at 119 (2022).

[141] Shannon Roesler, *Agency Reasons at the Intersection of Expertise and Presidential Preferences*, 71 ADMIN. L. REV. 491, 510–11 (2019).

[142] *See generally* Blake Emerson, *Public Care in Public Law: Structure, Procedure, and Purpose*, 16 HARV. L. & POL'Y REV. 35 (2021) (discussing the principle of public care).

where the federal government's failure to act has perpetuated and allowed for birth injustices in health care. Policy recommendations pursuant to named statutory authorities are offered. Section II.C describes how the efforts to dismantle the federal government and overhaul the regulatory process under the second Trump Administration not only impede the progress that has been made toward birth justice but also threaten to exacerbate existing maternal health inequities and birth injustices.

A. *Executive Qualifications and Statutory Obligations*

There are laws affording HHS significant leverage over the quality of care, provider access, and insurance coverage. Two of the most prominent health care statutes—the ACA[143] and Medicaid[144]—have influenced health equity and maternal health specifically. The ACA provides legal authority to improve health care access and quality, as well as authority to prohibit discrimination.[145] Medicaid is the largest insurance payer of maternal health services, which demonstrates the potential influence the program has—and can have—on birth justice.[146] Title X of the Public Health Services Act established the National Family Planning program, which covers wellness exams, certain infertility services, pregnancy testing and options counseling, contraceptives, and other preventive services.[147] These services are critical given the quality of preconception care and the birthing person's health before pregnancy are determinants for birthing and postpartum outcomes.[148] Additionally, there are more specific statutes governing HHS' maternal health

---

[143] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of the U.S. Code).

[144] Social Security Act § 1900, 42 U.S.C. § 1396.

[145] *See, e.g.*, 42 U.S.C § 18031(c) (requiring regulations establishing "criteria for the certification of health plans as qualified health plans"); *id.* § 18116(c) (allowing regulations to implement nondiscrimination provisions).

[146] *See* 42 U.S.C. § 1396; Usha Ranji, Alina Salganicoff, Jennifer Tolbert, Brittni Frederiksen & Ivette Gomez, *5 Key Facts About Medicaid and Pregnancy*, KFF (May 29, 2025), https://www.kff.org/medicaid/5-key-facts-about-medicaid-and-pregnancy/ [https://perma.cc/QFZ7-TFHG].

[147] 42 U.S.C. §§ 300–300a-6; CHRISTINA FOWLER, JULIA GABLE & BETH LASATER, RTI INT'L, FAMILY PLANNING ANNUAL REPORT: 2021 NATIONAL SUMMARY 1 (2022), https://opa.hhs.gov/sites/default/files/2022-09/2021-fpar-national-final-508.pdf (on file with the Lewis & Clark Law Review).

[148] *See, e.g.*, Teresa Harper, Wendy Kuohung, Lauren Sayres, Mary D. Willis & Lauren A. Wise, *Optimizing Preconception Care and Interventions for Improved Population Health*, 120 FERTILITY & STERILITY 438, 439–45 (2023); *see* HARSHAL KHEKADE, ASHWINI POTDUKHE, AVINASH B. TAKSANDE, MAYUR B. WANJARI & SEEMA YELNE, PRECONCEPTION CARE: A STRATEGIC INTERVENTION FOR THE PREVENTION OF NEONATAL AND BIRTH DISORDERS 2 (2023), https://assets.cureus.com/uploads/review_article/pdf/164081/20230629-10886-19m30lh.pdf [https://perma.cc/PES2-AHRH]; Ranji et al., *supra* note 146.

activities. HRSA within HHS has obligations under the Title V Maternal and Child Health Block Grant and the Healthy Start Initiative, for instance.[149] Related, Congress has in recent years enacted laws granting HHS authority to expand the perinatal workforce through the Improving Access to Maternal Health Act[150] and improve data collection and analysis at the state and local level through the Preventing Maternal Deaths Act.[151]

The ability of these laws to impact people's lives is impeded without regulatory action. Under each of these statutes, there is authority to promulgate regulations that create new programs, revise existing regulations to improve upon programs, and exercise enforcement discretion. Pursuant to these authorities, there have also been positive advancements resulting from federal administrative actions.

1. Oversight and Enforcement

The ACA includes a nondiscrimination provision known as Section 1557 or the Health Care Rights Law.[152] The law applies existing civil rights protections, including Title IX of the Education Amendments of 1972 and Title VI of the Civil Rights Act of 1964, to health programs and entities receiving federal financial assistance and prohibits discrimination on the basis of sex and race, color, and national origin, among other prohibitions.[153] The Secretary is explicitly granted authority to promulgate implementing regulations.[154] The HHS Office of Civil Rights (OCR) has interpreted the prohibition against sex discrimination to prohibit discrimination on the basis of pregnancy, childbirth, and related medical conditions.[155] Relatedly, OCR has issued guidance instructing pharmacies that it is discriminatory to refuse medications to patients to manage a pregnancy loss.[156]

HHS has taken some actions to hold providers accountable pursuant to Section 1557. Under the Biden Administration, OCR within HHS opened a civil rights investigation into Cedars-Sinai Hospital following the death of Kira Dixon

---

[149] *See* 42 U.S.C. § 254c-8.

[150] Improving Access to Maternity Care Act, Pub. L. No. 115-320, § 2, 132 Stat. 4437, 4437 (2018).

[151] Preventing Maternal Deaths Act of 2018, Pub. L. No. 115-344, § 2, 132 Stat. 5047, 5047–5051.

[152] Patient Protection and Affordable Care Act § 1557, 42 U.S.C. § 18116.

[153] *Id.* § 18116(a).

[154] *Id.* § 18116(c).

[155] *Section 1557: Protecting Individuals Against Sex Discrimination*, U.S. DEP'T OF HEALTH & HUM. SERVS. (Nov. 3, 2020), https://www.hhs.gov/civil-rights/for-individuals/section-1557/fs-sex-discrimination/index.html [https://perma.cc/W3ZS-LDGT].

[156] *See* Crowell & Moring, *OCR Issues Anti-Discrimination Guidance for Pharmacies Related to Reproductive Health Care Services*, CROWELL (July 25, 2022), https://www.cmhealthlaw.com/2022/07/ocr-issues-anti-discrimination-guidance-for-pharmacies-related-to-reproductive-health-care-services/ [https://perma.cc/9FVK-XK7V].

Johnson, as explained in the introduction.[157] HHS concluded that the investigation "uncovered evidence that Cedars-Sinai may have engaged in a pattern of inaction and/or neglect concerning the health risks associated with Black maternity patients."[158] During the investigation into Ms. Johnson's death, OCR found other irregularities in care, and the agency reviewed other complaints against the hospital alleging racial discrimination during labor and delivery.[159] The hospital and agency entered into a voluntary settlement agreement, where the hospital committed to provide additional trainings to providers and staff, including the American College of Obstetricians and Gynecologists (ACOG) Respectful Care eModules; to facilitate patient access to doulas; and to implement processes for patients to report allegations of bias and mistreatment.[160]

There are additional statutory authorities that task the federal government with ensuring federal monies are appropriately spent. The Social Security Act prescribes that hospitals participating in the Medicare program "must meet certain specified requirements" and authorizes the Secretary to "impose additional requirements if they are found necessary in the interest of the health and safety of the individuals who are furnished services in hospitals."[161] The HHS Centers for Medicare and Medicaid Services (CMS) requires hospitals to meet certain conditions of participation, which are designed to ensure entities receiving Medicaid, Medicare, and other federal funding are providing quality care.[162] In November 2024, CMS finalized regulations outlining specific conditions of participation for obstetric services, including requirements governing equipment, staffing, and quality

---

[157] Evans, *supra* note 7; *see supra* text accompanying notes 1–8.

[158] Letter from Michael Leoz, Reg'l Manager Off. of C.R., U.S. Dep't of Health & Hum. Servs., to Pamela S. Hamilton, Vice President of Risk Mgmt. & Brett Moodie, Corp. Couns., Cedars-Sinai Health Sys. (Nov. 12, 2024) (on file with the Lewis & Clark Law Review).

[159] The complaints alleged that the hospital ignored patients' pleas for help and denied pain medication, improperly performed an episiotomy without consent, and called child protective services after falsely accusing a patient of child abuse. *Id.*

[160] VOLUNTARY RESOLUTION AGREEMENT, *supra* note 24. *But see* Emily Alpert Reyes, *Protesters Demand Cedars-Sinai Do More to Protect Pregnant Patients of Color*, L.A. TIMES (Feb. 20, 2025, at 14:21 PT), https://www.latimes.com/california/story/2025-02-20/protesters-demand-cedars-sinai-do-more-to-protect-black-pregnant-patients [https://perma.cc/BS32-7L66] ("Federal officials reached a voluntary agreement with Cedars-Sinai last month on steps to improve maternal care for patients of color, but advocacy groups including 4Kira4Moms said it doesn't go far enough.").

[161] 42 C.F.R. § 482.1(a)(i)–(ii) (2026); *see* Social Security Act § 1861(e), 42 U.S.C. § 1396x(e).

[162] 42 C.F.R. pt. 482 (2026); *Conditions for Coverage (CfCs) & Conditions of Participation (CoPs)*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Sep. 10, 2024, at 18:21 PT), https://www.cms.gov/medicare/health-safety-standards/conditions-coverage-participation [https://perma.cc/9NK8-QB6H].

improvement.[163] Hospital conditions also generally require that patients be afforded a right to meaningfully participate in the development and implementation of their care, a right to refuse treatment, and the right to be free from all forms of abuse or mistreatment.[164] The failure to adhere to conditions of participation can result in a required corrective action plan, civil monetary penalties, and in the most extreme circumstances, an inability to receive reimbursements through the Medicare and Medicaid programs.[165]

2. Quality of Care

The federal government's financing of prenatal, labor and delivery, and post-partum care has influenced the delivery and quality of care received. The ACA section 3021 also requires the Secretary to "select models to be tested from models where the Secretary determines that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures."[166] Notably, the statute explicitly authorizes "medical homes that address women's unique health care needs."[167]

The CMS Innovation Center (CMMI) developed payment and delivery system models focused on maternal health for women enrolled in Medicaid and the Children's Health Insurance Programs. In 2025, CMMI began its newest alternative payment model, Transforming Maternal Health (TMaH), for state Medicaid agencies with a goal of reducing disparities in access and treatment.[168] Under TMaH, HHS has funded 15 state Medicaid programs to develop a "whole-person approach to pregnancy, childbirth, and postpartum care" that addresses the "physical, mental health, and social needs experienced during pregnancy."[169] CMMI previously operated the Strong Start Initiative for women enrolled in Medicaid, and the Children's Health Insurance Program.[170] The Strong Start Initiative's most successful model focused on birth centers, where midwives provided care and peer counselors provided education, referrals for additional

[163] Updating, Revising, and Finalizing Changes to Certain Medicaid and Medicare Programs, 89 Fed. Reg. 93912, 94592–94 (Nov. 27, 2024) (codified at 42 C.F.R. § 482.59).

[164] 42 C.F.R. § 482.13(b)(1)–(2), (c)(3), (e) (2026).

[165] Termination by CMS, 42 C.F.R. § 489.53 (2026); Corrective Action Plans & Civil Monetary Penalties, 45 C.F.R. §§ 180.80–180.90 (2026).

[166] Patient Protection and Affordable Care Act § 3021, 42 U.S.C. § 1315a(b)(2)(A).

[167] *Id.* § 1315a(b)(2)(B)(i).

[168] *TMaH (Transforming Maternal Health) Model*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Dec. 30, 2025, at 12:22 PT), https://www.cms.gov/priorities/innovation/innovation-models/transforming-maternal-health-tmah-model [https://perma.cc/6Z2T-HRHD].

[169] *Id.*

[170] *Strong Start for Mothers and Newborns Initiative: General Information*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/priorities/innovation/innovation-models/strong-start [https://perma.cc/L2HG-NYC3] (last visited Jan. 7, 2026).

services including nonmedical services and health education.[171] This model led to improved health outcomes, care processes, and reduced costs.[172] HHS has also provided funding directly to health centers to improve care quality. For instance, HRSA has provided funding through the Health Center Quality Improvement Fund to support health center efforts to improve innovations in virtual care.[173]

HHS has also partnered with physician organizations and hospitals to improve maternal healthcare. HHS and the ACOG entered into a cooperative agreement over a decade ago to create the Alliance for Innovation and Maternal Health (AIM), a quality improvement initiative that develops recommended treatment policies and training programs for hospitals.[174] These "safety bundles" currently address safe reduction of primary C-sections, perinatal mental health conditions, and postpartum hospital discharge transition.[175] Progress toward implementation is collected through quality measures,[176] and the hospitals that have adopted these "safety bundles" have documented improvements.[177] Forty-nine states, D.C., and Puerto Rico currently participate in the AIM program.[178] Similarly, the CDC has created Perinatal Quality Collaboratives (PQCs), which collaborate with hospitals, state health departments, universities, state chapters for nonprofit organizations, and/or health insurers to disseminate tools to improve clinical care, analyze performance data, and collaborate on learning.[179] CMS requires hospitals enrolled

---

[171] IAN HILL, LISA DUBAY, BRIGETTE COURTOT, SARAH BENATAR, BOWEN GARRETT ET AL., URB. INST., STRONG START FOR MOTHERS AND NEWBORNS EVALUATION: YEAR 5 PROJECT SYNTHESIS, VOLUME 1: CROSS-CUTTING FINDINGS 131 (2018), https://downloads.cms.gov/files/cmmi/strongstart-prenatal-finalevalrpt-v1.pdf [https://perma.cc/E8E4-36AQ].

[172] *Id.* at 134–35.

[173] *Quality Improvement Fund (QIF)—Innovation and Quality Improvement*, HEALTH RES. & SERVS. ADMIN. (June 2024), https://bphc.hrsa.gov/node/3121 [https://perma.cc/B994-8K47].

[174] Christie Allen, Isabel Taylor & Amy Ushry, *Alliance for Innovation on Maternal Health: Evolution of a Program to Address Maternal Morbidity and Mortality*, 48 SEMINARS PERINATOLOGY, no. 3, Apr. 2004, at 1, 1–4.

[175] *Patient Safety Bundles*, ALL. FOR INNOVATION ON MATERNAL HEALTH, https://saferbirth.org/patient-safety-bundles/#what-are-psbs [https://perma.cc/K5T3-TN9Y] (last visited Jan. 10, 2025) (providing links to AIM's patient safety bundles).

[176] *Data Process*, ALL. FOR INNOVATION ON MATERNAL HEALTH, https://saferbirth.org/aim-data/data-process/ [https://perma.cc/A824-9ZG9] (last visited Jan. 10, 2025).

[177] Christina Davidson, Stacie Denning, Kristin Thorp, Lynda Tyer-Viola, Michael Belfort, Haleh Sangi-Haghpeykar & Manisha Gandhi, *Examining the Effect of Quality Improvement Initiatives on Decreasing Racial Disparities in Maternal Morbidity*, 31 BMJ QUALITY & SAFETY 670, 676 (2022).

[178] *Alliance for Innovation on Maternal Health (AIM)*, HEALTH RES. & SERVS. ADMIN. (Jan. 2025), https://mchb.hrsa.gov/programs-impact/programs/alliance-innovation-maternal-health [https://perma.cc/3C8M-7FVF].

[179] CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC), *Perinatal Quality Collaboratives (PQCs)*, at 0:40, (YouTube, July 30, 2020), https://www.youtube.com/watch?v=u_PYnV9pdpM [https://perma.cc/9K53-C43X].

in the Medicare program to report on their participation in a maternal health quality improvement initiative, which can be a PQC or implementing patient safety practice or bundles.[180] Thirty-six states are currently participating in a PQC.[181]

3. Perinatal Workforce Development

The Secretary of HHS, through HRSA, is authorized to address perinatal health disparities, and this authority has been used to expand the maternal health workforce. Specifically, the statute provides, "The Secretary, acting through the Administrator of the Health Resources and Services Administration, Maternal and Child Health Bureau, shall under authority of this section continue in effect the Healthy Start Initiative."[182] The statute notes that the agency should also consider when awarding grants the extent that an entity will facilitate "a comprehensive approach to women's health care to improve perinatal outcomes."[183] The statute creating the Title V Maternal and Child Health Block Grant program authorizes funding to be awarded to states, and states are given flexibility to allocate funds for a range of purposes, including "training with respect to maternal and child health."[184] Finally, the Improving Access to Maternity Care Act directs HRSA to identify maternity care professional shortage areas, and use this information to distribute loan repayment and scholarship assistance.[185]

Illustratively, the HRSA funds initiatives to train new certified nurse midwives and community-based doulas through its Healthy Start Initiative.[186] HRSA has also provided funding to train primary care physicians on maternal health care,[187]

---

[180] *FY 2023 Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospitals Prospective Payment Systems (LTCH PPS) Final Rule—CMS-1771-F*, CTRS. FOR MEDICARE & MEDICAID SERVS.: NEWSROOM (Aug. 1, 2022) [hereinafter *FY 2023 IPPS and LTCH PPS*], https://www.cms.gov/newsroom/fact-sheets/fy-2023-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospital-prospective [https://perma.cc/FJ9K-MRJK].

[181] *See State Perinatal Quality Collaboratives*, CTRS. FOR DISEASE CONTROL & PREVENTION: MATERNAL INFANT HEALTH (May 15, 2024), https://www.cdc.gov/maternal-infant-health/pqc/state-pqcs.html [https://perma.cc/29DW-GWVH].

[182] 42 U.S.C. § 254c-8(a)(1).

[183] *Id.* § 254c-8(b)(2)(B)(ii).

[184] 42 U.S.C. § 701(a)(2).

[185] Improving Access to Maternity Care Act, Pub. L. No. 115-320, § 2, 132 Stat. 4437, 4437 (2018) (codified at 42 U.S.C. § 254e(k)); *What Is Shortage Designation?*, HEALTH RES. & SERVS. ADMIN. (June 2023), https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation [https://perma.cc/V8EG-Q6JV] (explaining how shortage designations help the government distribute medical providers to needed areas through different incentives).

[186] *E.g.*, HEALTH RES. & SERVS. ADMIN., HRSA-22-148, HEALTHY START SUPPLEMENT: COMMUNITY-BASED DOULAS (2022); HEALTH RES. & SERVS. ADMIN., HRSA-23-014, ADVANCED NURSING EDUCATION WORKFORCE (ANEW) PROGRAM (2023).

[187] HEALTH RES. & SERVS. ADMIN., HRSA-21-014, PRIMARY CARE TRAINING AND ENHANCEMENT-COMMUNITY PREVENTION AND MATERNAL HEALTH (PCTE-CPMH) (2021).

incentivize maternity care providers to serve in select underserved areas,[188] and support midwifery programs in rural and underserved communities.[189] Finally, HRSA has provided loan repayment to nurses in exchange for a commitment to work in areas with a shortage of nurses.[190]

4. Provider Access

Existing statutes also govern which providers are covered under insurance plans, subsequently impacting insured individuals' access to certain providers. The ACA includes a network adequacy standard which requires that plans sold on ACA marketplaces have a "sufficient choice of providers."[191] The statute provides that "[t]he Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans."[192] HHS has imposed time, distance, and appointment wait time standards for obstetrician and gynecological services.[193] There is also a separate statutory requirement that plans cover certain essential community providers, defined as those who provide care to low-income, medically underserved individuals, including federally qualified health centers, Ryan White providers, Title X family planning providers, certain children's hospitals, and certain student health centers.[194] Beyond this limited statutory language, network adequacy standards are largely defined in regulations and guidance. Finally, the ACA also prohibits health insurers offering group and individual plans from discriminating against providers acting within the scope of their license or certification.[195]

Social safety net programs play a critical role in maternal health outcomes for uninsured, underinsured, and insured. The Title X family planning program provides funding for contraceptives, well-woman visits, basic fertility services, and

---

[188] *NHSC Students to Service Loan Repayment Program*, HEALTH RES. & SERVS. ADMIN. (Sep. 2025) https://nhsc.hrsa.gov/loan-repayment/nhsc-students-to-service-loan-repayment-program [https://perma.cc/8GSJ-B94F].

[189] *Maternity Care Nursing Workforce Expansion (MatCare) Program*, HEALTH RES. & SERVS. ADMIN. (Dec. 2023), https://bhw.hrsa.gov/programs/maternity-care-nursing-workforce-expansion [https://perma.cc/DX8A-TGU4].

[190] *Apply to the Nurse Corps Loan Repayment Program*, HEALTH RES. & SERVS. ADMIN. (Sep. 2025), https://bhw.hrsa.gov/funding/apply-loan-repayment/nurse-corps [https://perma.cc/9RBY-8BYB].

[191] Patient Protection and Affordable Care Act § 1311, 42 U.S.C. § 18031(c)(1)(B).

[192] 42 U.S.C. § 18031(c)(1).

[193] Letter from Ctr. for Consumer Info. & Ins. Oversight (CCIIO), Ctrs. for Medicare & Medicaid Servs. (CMS), 2023 Final Letter to Issuers in the Federally-Facilitated Exchanges 10 (Apr. 28, 2022), https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/final-2023-letter-to-issuers.pdf [https://perma.cc/3WUB-V4PZ].

[194] *See* 42 U.S.C. § 18031(c)(1)(C); *Essential Community Providers*, AM. ACAD. OF HIV MED., https://aahivm.org/essential-community-providers/ [https://perma.cc/963M-C9KR] (last visited Jan. 22, 2026).

[195] 42 U.S.C. § 300gg-5(a).

HIV and cancer screenings, amongst other services.[196] Family planning and preventive services correlate to improve maternal health outcomes, and these providers often provide critical linkages between their confirmed-pregnant patients and prenatal care.[197] The Title X program issues grants directly to state and local governments, as well as nonprofit organizations, and supports direct care delivery and infrastructure.[198] Title X-funded services are statutorily required to be no or low cost to patients and confidential; subsequently, people—without regard to insurance status—seek the confidential services available.[199] Given the low reimbursement rates for Medicaid, discussed more below, Title X providers are often among the low number of providers willing to provide care to Medicaid recipients.[200] During the Trump Administration's first term, HHS dedicated $1.6 million to training and technical assistance on hypertension screenings at Title X clinics.[201] This commitment was made in the agency's action plan on maternal health with a recognition that cardiovascular conditions contribute significantly to maternal mortality and morbidity.[202]

5. Health Insurance Quality

The ACA improved both the quality of insurance coverage and access to coverage for women of reproductive age and new mothers.[203] Notable benefit standards within the ACA are the Essential Health Benefits (EHBs) and the preventive services requirement. The EHBs include ten broad categories of services

---

[196] *About Title X Service Grants*, U.S. DEP'T OF HEALTH & HUM. SERVS., OFF. OF POPULATION AFFS., https://opa.hhs.gov/grant-programs/title-x-service-grants/about-title-x-service-grants [https://perma.cc/JM3F-2XAG] (last visited Mar. 7, 2026).

[197] *E.g.*, *Establishing and Providing Effective Referrals for Clients: A Toolkit for Family Planning Providers*, REPROD. HEALTH NAT'L TRAINING CTR. (July 2022), https://rhntc.org/resources/establishing-and-providing-effective-referrals-clients-toolkit-family-planning-providers [https://perma.cc/7ACG-9ZDQ].

[198] *See, e.g.*, 42 U.S.C. §§ 300, 300a.

[199] 42 U.S.C. §§ 300, 300a; *About Title X Service Grants*, *supra* note 196.

[200] ADAM SONFIELD, ANDREA ROWAN, JOSEPH L. ALIFANTE & RACHEL BENSON GOLD, GUTTMACHER INST., ASSESSING THE GAP BETWEEN THE COST OF CARE FOR TITLE X FAMILY PLANNING PROVIDERS AND REIMBURSEMENT FROM MEDICAID AND PRIVATE INSURANCE 13 (2016), https://www.guttmacher.org/sites/default/files/report_pdf/title-x-reimbursement-gaps.pdf [https://perma.cc/UC5F-M6WS]; *see infra* Section II.B.

[201] HEALTHY WOMEN, HEALTHY PREGNANCIES, *supra* note 25, at 31.

[202] *Id.*

[203] MUNIRA Z. GUNJA, SARA R. COLLINS, MICHELLE M. DOTY & SOPHIE BEUTEL, COMMONWEALTH FUND, HOW THE AFFORDABLE CARE ACT HAS HELPED WOMEN GAIN INSURANCE AND IMPROVED THEIR ABILITY TO GET HEALTH CARE 2 (2017), https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2017_aug_gunja_women_hlt_coverage_care_biennial.pdf [https://perma.cc/WXZ9-FLP4].

including pregnancy, maternity, and newborn care.[204] Before the ACA, only 12% of individual health plans covered maternity services.[205] Women without the option to purchase a plan with maternity benefits coverage would need to purchase supplemental insurance coverage, also known as maternity riders, if they planned on becoming pregnant.[206] These insurance riders could cost up to twice the amount of an individual policy premium.[207] Further, given nearly 50% of births in this country are unplanned, purchasing such a rider has proven impractical for many.[208] The ACA requires individual and small group plans, as well as Alternative Benefit Plans available to the Medicaid expansion population, to cover the EHBs.[209] Thirteen million people gained access to maternity services under the EHBs, following the ACA.[210]

The ACA also requires most insurance plans to cover certain preventive services, including women's preventive services without cost-sharing, U.S. Preventive Services Task Force recommendations, and immunizations.[211] The required women's preventive services are not defined in statute.[212] HHS has, in guidance, defined this benefit to include coverage for breastfeeding counseling and supplies, diabetes screenings during and after pregnancy, pregnant and postpartum

[204] U.S. Ctrs. for Medicare & Medicaid Servs., *Health Benefits & Coverage: What Marketplace Health Insurance Plans Cover*, HEALTHCARE.GOV, https://www.healthcare.gov/coverage/what-marketplace-plans-cover/ [https://perma.cc/3G56-VBZG] (last visited Jan. 11, 2026).

[205] JAMILLE FIELDS ALLSBROOK & OSUB AHMED, CTR. FOR AM. PROGRESS, BUILDING ON THE ACA: ADMINISTRATIVE ACTIONS TO IMPROVE MATERNAL HEALTH 1, 4 (2021), https://www.americanprogress.org/wp-content/uploads/sites/2/2021/03/MaternalHealth-brief.pdf [https://perma.cc/DFJ5-BNMP].

[206] *Id.* at 6; Dania Palanker, Kevin W. Lucia & Dimitra Panteli, *What Makes Covering Maternity Care Different?*, HEALTH AFFS. FOREFRONT (June 29, 2017), https://www.healthaffairs.org/content/forefront/makes-covering-maternity-care-different (on file with the Lewis & Clark Law Review).

[207] KAREN POLLITZ, MILA KOFMAN, ALINA SALGANICOFF & USHA RANJI, HENRY J. KAISER FAM. FOUND., MATERNITY CARE AND CONSUMER-DRIVEN HEALTH PLANS 2 (2007), https://www.kff.org/wp-content/uploads/2013/01/7636.pdf [https://perma.cc/D8RD-UNS5].

[208] ISABEL V. SAWHILL & KATHERINE GUYOT, BROOKINGS, PREVENTING UNPLANNED PREGNANCY: LESSONS FROM THE STATES 2 (2019), https://www.brookings.edu/wp-content/uploads/2019/06/Preventing-Unplanned-Pregnancy-2.pdf [https://perma.cc/C44R-637R].

[209] *Information on Essential Health Benefits (EHB) Benchmark Plans*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Jan. 14, 2025, at 15:10 PT), https://www.cms.gov/marketplace/resources/data/essential-health-benefits [https://perma.cc/YBV6-VQ7Y].

[210] Christy M. Gamble & Jamila Taylor, *Maternity Care Under ACA Repeal: Implications for Black Women's Maternal Health*, CTR. FOR AM. PROGRESS (Aug. 7, 2017), https://www.americanprogress.org/article/maternity-care-aca-repeal/ [https://perma.cc/QA2L-SN5V].

[211] Patient Protection and Affordable Care Act § 1001, 42 U.S.C. § 300gg–13 (amending the Public Health Service Act § 2713).

[212] *See id.*

anxiety screenings, and contraceptives.[213] The U.S. Preventive Services Task Force has also recommended certain maternal health services, including screenings for hypertensive disorders, gestational diabetes, STIs, and HIV for pregnant persons, as well as iron deficiency and folic acid medications.[214] Similarly, CDC expert recommendations on vaccines for pregnant persons, including the COVID-19 and flu vaccine, have previously led to coverage under the ACA preventive services requirement.[215]

The ACA also improved access to coverage. The law provided for financial assistance to purchase individual health plans and expanded eligibility for the Medicaid program.[216] An estimated 20 million people gained health insurance coverage thanks to the ACA, and relevant to this Article, Medicaid expansion has been associated with improved maternal health outcomes.[217] Relatedly, the American Rescue Plan created an additional pathway for states to extend Medicaid postpartum coverage for one year to pregnant people who might not otherwise qualify for Medicaid.[218] States must submit proposals for this extension to HHS, and HHS has to date approved 49 states including D.C.[219] Similarly, recent studies have found that the ACA's Medicaid expansion has resulted in increased utilization

---

[213] *Women's Preventive Services Guidelines*, HEALTH RES. & SERVS ADMIN. (Dec. 2025), https://www.hrsa.gov/womens-guidelines [https://perma.cc/R63F-WFW3].

[214] *Recommendation Topics*, U.S. PREVENTATIVE SERVS. TASK FORCE, https://www.uspreventiveservicestaskforce.org/uspstf/ (enter "pregnancy" in keyword search) [https://perma.cc/EC5B-72BD] (last visited Jan. 11, 2026).

[215] Jennifer Kates, *ACIP, CDC, and Insurance Coverage of Vaccines in the United States*, KFF (June 13, 2025), https://www.kff.org/other-health/acip-cdc-and-insurance-coverage-of-vaccines-in-the-united-states/ [https://perma.cc/BBM2-6SZ2]; *see Guidelines for Vaccinating Pregnant Women*, CTRS. FOR DISEASE CONTROL & PREVENTION: PREGNANCY & VACCINATION (Aug. 22, 2025), https://www.cdc.gov/vaccines-pregnancy/hcp/vaccination-guidelines/index.html [https://perma.cc/LAE7-64VB].

[216] JARED ORTALIZA, MATT MCGOUGH & CYNTHIA COX, KFF, THE AFFORDABLE CARE ACT 101, at 2, 8, 10, 14 (2025), https://files.kff.org/attachment/health-policy-101-the-affordable-care-act.pdf [https://perma.cc/QVJ6-THKF].

[217] Gerald F. Kominski, Narissa J. Nonzee & Andrea Sorensen, *The Affordable Care Act's Impacts on Access to Insurance and Health Care for Low-Income Populations*, 38 ANN. REV. PUB. HEALTH 489, 491 (2017); Maria W. Steenland & Laura R. Wherry, *Medicaid Expansion Led to Reductions in Postpartum Hospitalizations*, 42 HEALTH AFFS. 18, 22–24 (2023).

[218] 42 U.S.C. § 1396a(e)(16); *Expanding Medicaid Coverage for Birthing People to One Year Postpartum*, AM. PUB. HEALTH ASS'N (Oct. 25, 2021), https://www.apha.org/policy-and-advocacy/public-health-policy-briefs/policy-database/2022/01/07/expanding-medicaid-coverage-for-birthing-people-to-one-year-postpartum [https://perma.cc/F3H3-QF95].

[219] As of January 2025, Arkansas is the only state that has not extended Medicaid pregnancy coverage beyond 60 days postpartum as required in the statute. Wisconsin has only extended this coverage to 90 days. *Medicaid Postpartum Coverage Extension Tracker*, KFF (Jan. 17, 2025), https://www.kff.org/improved/issue-brief/improved-postpartum-coverage-extension-tracker/ [https://perma.cc/BBT2-XZ5H].

of services during pregnancy in part by promoting access to OBGYNs.[220] Notably, people who had recently given birth were 60% less likely to have foregone medical care due to cost following the ACA coverage provisions going into effect.[221]

6. Research and Assessments

HHS collects data and engages in analysis regarding maternal health outcomes. The CDC has maintained a number of databases including the Pregnancy Mortality Surveillance System, where medical epidemiologists review and analyze vital records to understand pregnancy-related deaths,[222] and the Pregnancy Risk Assessment Monitoring System (PRAMS), which collects and monitors data on women and infants deemed high risk for adverse health outcomes.[223] In the insurance context, state Medicaid programs, as of 2024, are required to report to CMS on the Child Core Data Set, which is a set of care quality standards; this reporting requirement currently includes certain maternal and perinatal quality measures such as prenatal and postpartum care and low-risk cesarean delivery.[224] Under the Biden Administration, HHS began to develop the Maternal Health Measurement Framework, which "represents a desired set of measures to assess progress on addressing the overall maternal health crisis."[225]

---

[220] Madeline Guth & Karen Diep, *What Does the Recent Literature Say About Medicaid Expansion?: Impacts on Sexual and Reproductive Health*, KFF (June 29, 2023), https://www.kff.org/improved/issue-brief/what-does-the-recent-literature-say-about-medicaid-expansion-impacts-on-sexual-and-reproductive-health/ [https://perma.cc/6F8L-VHYT]; *see also* Summer Sherburne Hawkins, Krisztina Horvath, Alice Noble & Christopher F. Baum, *ACA and Medicaid Expansion Increased Breast Pump Claims and Breastfeeding for Women with Public and Private Insurance*, 32 WOMEN'S HEALTH ISSUES 114, 120 (2022) (showing that the ACA and Medicaid expansion increased access to breast pumps).

[221] STACEY MCMORROW, EMILY M. JOHNSTON, TYLER W. THOMAS & GENEVIEVE M. KENNEY, URB. INST., CHANGES IN NEW MOTHERS' HEALTH CARE ACCESS AND AFFORDABILITY UNDER THE AFFORDABLE CARE ACT 10 (2020), https://www.urban.org/sites/default/files/publication/102984/changes-in-new-mothers-health-care-access-and-affordability-under-aca.pdf [https://perma.cc/ZRY4-FWD3].

[222] *Data from the Pregnancy Mortality Surveillance System*, CTRS. FOR DISEASE CONTROL & PREVENTION (Dec. 18, 2025), https://www.cdc.gov/maternal-mortality/php/pregnancy-mortality-surveillance-data/index.html [https://perma.cc/H2MP-EW3X].

[223] *About PRAMS*, CTRS. FOR DISEASE CONTROL & PREVENTION: PREGNANCY RISK ASSESSMENT MONITORING SYS. (PRAMS) (May 15, 2024), https://www.cdc.gov/prams/about/index.html [https://perma.cc/59RQ-2JEG].

[224] 42 C.F.R. §§ 437.1–437.15 (2026). CMS is required to update the Child Core Set annually. *Children's Health Care Quality Measures*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures [https://perma.cc/H9S5-6R9F] (last visited Jan. 11, 2026). And the Bipartisan Budget Act of 2018 added the requirement for states to report on the Child Core Set. Pub. L. No. 115-123, § 50102(b)(1)(B), 132 Stat. 175, 175.

[225] U.S. DEP'T OF HEALTH & HUM. SERVS., ADDRESSING THE MATERNAL HEALTH CRISIS IN THE UNITED STATES: AN UPDATE FROM THE U.S. DEPARTMENT OF HEALTH AND

HHS also supports state and local governments in collecting information on maternal health outcomes. Pursuant to the Preventing Maternal Deaths Act, the CDC provides funding and technical assistant to states establishing and operating Maternal Mortality Review Committees.[226] Maternal Mortality Review Committees review data and information on deaths occurring during pregnancy or within one year following the end of a pregnancy.[227] These committees provide critical information regarding the causes of death and can offer critical information in the development of solutions.[228] To receive federal support under this Act, Maternal Mortality Review Committees must be multidisciplinary and diverse. Membership can include public health officials, epidemiologists, statisticians, representation from different clinical specialties, community organizations, and individuals or organizations from the most impacted areas.[229]

Lastly, HHS provides financial support through grants to private individuals and institutions, such as colleges and universities. The National Institutes of Health (NIH) established the Maternal Health Research Centers of Excellence in 2019, with the goal of issuing $168 million in grants to "develop and evaluate innovative approaches to reduce pregnancy-related complications and deaths and promote maternal health equity."[230] Generally, the NIH has funded research on a variety of issues to understand the implications for maternal health outcomes including environmental factors,[231] substance use disorders,[232] oral health,[233] community-

HUMAN SERVICES 33 (2024), https://aspe.hhs.gov/sites/default/files/documents/688063d3176311f3b2ee6c14f02bf4e4/rtc-maternal-health.pdf [https://perma.cc/Y9WN-GPRN].

[226] Preventing Maternal Deaths Act of 2018 § 2, 42 U.S.C. § 247b-12.

[227] *About Maternal Mortality Review Committees*, CTRS. FOR DISEASE CONTROL & PREVENTION (May 15, 2024), https://www.cdc.gov/maternal-mortality/php/mmrc/index.html [https://perma.cc/KS8E-BLGC].

[228] *Issue Brief: Maternal Mortality Review Committees*, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS (Apr. 2025), https://www.acog.org/advocacy/policy-priorities/maternal-mortality-prevention/issue-brief-maternal-mortality-review-committees [https://perma.cc/8MKE-HZ8N].

[229] 42 U.S.C. § 247b-12(d).

[230] *NIH establishes Maternal Health Research Centers of Excellence*, NAT'L INSTS. OF HEALTH (Aug. 17, 2023), https://www.nih.gov/news-events/news-releases/nih-establishes-maternal-health-research-centers-excellence [https://perma.cc/4PCR-EZHH].

[231] *E.g.*, NAT'L INSTS. OF HEALTH, NOT-OD-22-174, NOTICE OF INTENT TO PUBLISH A FUNDING OPPORTUNITY ANNOUNCEMENT FOR LIMITED COMPETITION: ENVIRONMENTAL INFLUENCES ON CHILD HEALTH OUTCOMES (ECHO) PREGNANCY AND PEDIATRIC COHORT STUDY SITES (2022).

[232] *E.g.*, NAT'L INSTS. OF HEALTH, NOT-DA-26-003, NOTICE OF SPECIAL INTEREST (NOSI): CONSEQUENCES OF PRENATAL FENTANYL EXPOSURE (2024).

[233] *E.g.*, NAT'L INSTS. OF HEALTH, NOT-DE-23-005, NOTICE OF SPECIAL INTEREST (NOSI): MATERNAL HEALTH AND THE DENTAL, ORAL, AND CRANIOFACIAL DEVELOPMENT OF THEIR CHILDREN (2023).

engaged research,[234] and develop point of care diagnostic services,[235] among many other topics.

Further, the federal government can and has considered, across issue areas, how policies impact different communities. For instance, President Biden signed an executive order entitled, Advancing Racial Equity and Support for Underserved Communities through the Federal Government.[236] While the Order alone did not substantially address maternal health inequities, it sent a signal regarding the Administration's priorities, and in the health care context, this included prioritizing health equity. Specifically, the Order directed federal agencies to "assess whether underserved communities and their members face systemic barriers in accessing benefits and opportunities available pursuant to those policies and programs" and explained that "[a]ffirmatively advancing equity, civil rights, racial justice, and equal opportunity is the responsibility of the whole of our Government."[237] The long-standing Executive Order 12866, signed in 1993 by President Bill Clinton and reaffirmed under President Barack Obama, provides, "in choosing among alternative regulatory approaches, agencies should select those approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts; and equity)."[238] This directs agencies to consider the impact they have on all regulatory actions, including the extent that their policies might impact equity.

B. Missed Opportunities and Policy Recommendations

Despite some progress toward addressing inequities, the healthcare system is still inequitable for birthing people. A cross-sector of structural problems has caused or perpetuated maternal health inequities, but the healthcare system, and subsequently HHS, is the focus of this Article.[239] The systemic failure to act undermines patient autonomy: If women and birthing people are mistreated when accessing care; coerced into receiving certain procedures and services; have limited

---

[234] *E.g.*, DEP'T OF HEALTH & HUM. SERVS., NAT'L INSTS. OF HEALTH, RFA-HD-22-024, COMMUNITY ENGAGED RESEARCH ON PREGNANCY RELATED AND ASSOCIATED INFECTIONS AND SEPSIS MORBIDITY AND MORTALITY (2022).

[235] *E.g.*, NAT'L INSTS. OF HEALTH, NOT-EB-23-005, NOTICE OF SPECIAL INTEREST (NOSI): SMALL BUSINESS INITIATIVES FOR INNOVATIVE TOOLS AND TECHNOLOGIES FOR IMPROVING OUTCOMES FOR MATERNAL HEALTH (2023).

[236] Exec. Order No. 13985, 86 Fed. Reg. 7009 (Jan. 25, 2021).

[237] *Id.* at 7009–10.

[238] Exec. Order No. 12866, 58 Fed. Reg. 51735, 51735 (Oct. 4, 1993); Exec. Order No. 13563, 76 Fed. Reg. 3821, 3821 (Jan. 21, 2011).

[239] *See generally* Elizabeth Tobin-Tyler, *Black Mothers Matter: The Social, Political and Legal Determinants of Black Maternal Health Across the Lifespan*, 25 J. HEALTH CARE L. & POL'Y 49 (2022) (explaining the interconnected systems that have perpetuated inequities in maternal health).

to no availability for sought-after providers and birthing support; and either cannot afford to pay out of pocket or do not have insurance coverage for providers and birthing support, birthing circumstances, and services; then the autonomy that birth justice demands cannot be realized. The voices of birthing people, providers, and birthing support persons are included in this Section to highlight first-hand accounts of the problem.

1. *No Accountability for Discrimination*

"Everything that came out of her mouth was the color of my skin. She goes 'You're the first dark person I've ever had.' It just kept going on for like 20 minutes. I sat there and had to deal with that. After that, I left and never went back."[240]

The U.S. healthcare system has not successfully employed a carrot-or-stick approach to addressing discriminatory and low-quality maternal health care. The federal government, and subsequently taxpayers, are largely paying for this low-quality care through federal financial assistance.[241] Because most hospitals receive Medicare funding and most U.S. births still occur in the hospital, most of the hospitals where low-quality or discriminatory care is being delivered takes place with the assistance of federal funding.[242] Additionally, Medicaid pays for over 40% of births in this country.[243]

It is difficult to determine from publicly available information how many complaints and investigations HHS OCR has undertaken for discrimination in pregnancy-related care, but a review of the agency's website, which includes information dating back to 2006, found only two related investigations and settlements.[244] HHS rarely withholds federal funds or imposes civil penalties for the

[240] Amnesty International, *supra* note 14, at 18.

[241] *See* Anna Bernstein, Andrea Flynn & Vina Smith- Ramakrishnan, *Medicaid Has a Critical Role in More Equitable Maternal Health Care*, CENTURY FOUND. (Sep. 10, 2024), https://tcf.org/content/report/medicaid-has-a-critical-role-in-more-equitable-maternal-health-care/ [https://perma.cc/ZQ4G-8D34].

[242] AM. HOSP. ASS'N, FACT SHEET: MAJORITY OF HOSPITAL PAYMENTS DEPENDENT ON MEDICARE OR MEDICAID 1–2 (2024), https://www.aha.org/system/files/media/file/2022/05/fact-sheet-majority-hospital-payments-dependent-on-medicare-or-medicaid-congress-continues-to-cut-hospital-reimbursements-for-medicare.pdf [https://perma.cc/W6TY-MZQZ] (listing the percentage of hospitals treating majority Medicare and Medicaid patients by state); NAT'L ACADS. OF SCIS., ENG'G & MED., BIRTH SETTINGS IN AMERICA: OUTCOMES, QUALITY, ACCESS, AND CHOICE 32–33 (Susan C. Scrimshaw & Emily P. Backes eds., 2020); Elizabeth Kukura, *Rethinking the Infrastructure of Childbirth*, 91 UMKC L. REV. 497, 539 (2023).

[243] Ctrs. for Medicare & Medicaid Servs., *Maternal & Infant Health Care Quality*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/maternal-infant-health-care-quality [https://perma.cc/24J4-PHNR] (last visited Jan. 12, 2026).

[244] In addition to the investigation into Cedars-Sinai mentioned above, OCR reached an

failure to comply with civil rights laws given it can have widespread implications for health care access.[245] For instance, despite the voluntary agreement that OCR reached with Cedars-Sinai hospital, Kira Dixon Johnson's husband and other advocates have complained that the agreement did not result in any accountability for the providers or hospital involved.[246]

HHS should implement additional accountability measures and undertake enforcement action, pursuant to Section 1557, for discriminatory practices. Section 1557 explicitly notes that the existing civil rights enforcement mechanisms apply, which OCR has long had authority to enforce.[247] HHS could use this authority more frequently to withhold federal financial assistance from discriminatory providers and hospitals. Financial accountability could have a broad impact on all services covered under the federal programs and should not be taken lightly. On the other hand, terminating federal funding or otherwise imposing civil penalties for discriminatory practices and behaviors would send a powerful signal and provide significant motivation for entities in violation of civil rights protections

---

agreement in 2011 with a hospital after a deaf patient complained that she was not provided a sign language interpreter while receiving prenatal care. *Recent Civil Rights Resolution Agreements & Compliance Reviews*, U.S. DEP'T OF HEALTH & HUM. SERVS. (Jan. 16, 2025), https://www.hhs.gov/civil-rights/for-providers/compliance-enforcement/agreements/index.html (on file with the Lewis & Clark Law Review); *see also* Courtney Rozen, *Women Harmed by Doctors, Then Failed by US Civil Rights Watchdog*, BLOOMBERG L. (Aug. 28, 2024, at 08:04 PDT), https://news.bloomberglaw.com/health-law-and-business/women-harmed-by-doctors-then-failed-by-us-civil-rights-watchdog (on file with the Lewis & Clark Law Review) (detailing how the OCR is overworked and underfunded, so it rarely pursues holding doctors or hospitals accountable); Jamille Fields Allsbrook & Katie Keith, *ACA Section 1557 as a Tool for Anti-Racist Health Care*, HEALTH AFFS. FOREFRONT (Dec. 8, 2021), https://www.healthaffairs.org/content/forefront/aca-section-1557-tool-anti-racist-health-care (on file with the Lewis & Clark Law Review) (summarizing health disparities persisting after the ACA and highlighting ways the HHS OCR could further use Title of VI the Civil Rights Act and Section 1557 of the ACA to reduce health disparities and advance racial equity).

[245] *See How OCR Enforces Civil Rights Discrimination Laws and Regulations*, U.S. DEP'T OF HEALTH & HUM. SERVS.: C.R. (Sep. 29, 2015), https://www.hhs.gov/civil-rights/for-providers/compliance-enforcement/enforcement-process/index.html [https://perma.cc/5Y2K-4KFQ]; *see also* CHRISTINE J. BACK & JARED P. COLE, CONG. RSCH. SERV., R47109, FEDERAL FINANCIAL ASSISTANCE AND CIVIL RIGHTS REQUIREMENTS 15–17 (2022) (explaining federal agencies' authority to interpret and apply civil rights statutes conditioning federal financial assistance on compliance; this authority includes terminating and suspending federal funding, but "agency investigations most commonly end in a recipient's agreement to reform its discriminatory practices").

[246] *See* VOLUNTARY RESOLUTION AGREEMENT, *supra* note 24; Evans, *supra* note 7; Emily Alpert Reyes, *Cedars-Sinai, Federal Agency Reach Agreement on Maternal Care for Patients of Color*, L.A. TIMES (Jan. 16, 2025, at 13:03 PT), https://www.latimes.com/california/story/2025-01-16/cedars-sinai-federal-agency-announce-agreement-on-maternal-care-for-patients-of-color [https://perma.cc/YL6X-63K7].

[247] *See* Patient Protection and Affordable Care Act § 1557, 42 U.S.C. § 18116.

to alter institutional practices and individual behaviors. As a condition to restore funding for hospitals and health systems, CMS could establish an improvement plan with a designated timeline and metrics for improvement.

OCR could provide guidance on prohibited behavior, including identifying examples of discriminatory practices and affirmative obligations in the maternal health context. Even prior to the ACA, the regulations to implement Title VI of the Civil Rights Act did not specify provider conduct considered racially discriminatory.[248] OCR has previously issued similar guidance as it relates to discrimination on the basis of disability status, particularly for people living with HIV, and discrimination on the basis of national origin as it relates to people with limited English proficiency.[249] Guidance, as well as consistent enforcement actions, have served as notice to hospitals and health systems regarding the behavior that will not be tolerated legally, and it can serve as a deterrent against unlawful behavior.[250] More importantly, deterring bad behavior will help some birthing people avoid mistreatment.

HHS has begun to award hospitals and health systems the designation of "birthing friendly" if these hospitals report their progress on CMS' Maternal

---

[248] Sidney D. Watson, *Reinvigorating Title VI: Defending Health Care Discrimination—It Shouldn't Be So Easy*, 58 FORDHAM L. REV. 939, 947–48 (1990); Sidney D. Watson, *Lessons from Ferguson and Beyond: Bias, Health, and Justice*, 18 MINN. J.L. SCI. & TECH. 111,139–40 (2017).

[249] *See* Allsbrook & Keith, *supra* note 244.

[250] For example, OCR has released guidance outlining behaviors and practices for language access services to ensure compliance with the prohibition against discrimination on the basis of national origin. U.S. DEP'T OF HEALTH & HUM. SERVS., OFF. FOR C.R., GUIDANCE TO FEDERAL FINANCIAL ASSISTANCE RECIPIENTS REGARDING TITLE VI PROHIBITION AGAINST NATIONAL ORIGIN DISCRIMINATION AFFECTING LIMITED ENGLISH PROFICIENT PERSONS 5, 11 (2003), https://www.hhs.gov/sites/default/files/ocr/civilrights/resources/specialtopics/lep/lepguidance.pdf [https://perma.cc/Q25G-4E49]. OCR has also instructed insurers that it was a violation of the ACA Section 1557 to engage in adverse tiering, a practice of placing all HIV medications on the formulary tier with the highest cost sharing. This OCR decision led to insurers subject to the complaint, as well as insurers who were not the subject of the complaint, ending this practice. Douglas B. Jacobs & Benjamin D. Sommers, *Using Drugs to Discriminate—Adverse Selection in the Insurance Marketplace*, 372 NEJM 399, 399–402 (2015); Administrative Complaint, from AIDS Inst. & Nat'l Health L. Program to Off. of C.R., U.S. Dep't of Health & Hum. Servs., Discriminatory Pharmacy Benefits Design in Select Qualified Health Plans Offered in Fla. (May 29, 2014), https://healthlaw.org/wp-content/uploads/2019/07/HIV-OCR-complaint-5-29-14-Final.pdf [https://perma.cc/93CC-XHSL]; *see also* Press Release, HIV+ HEP Pol'y Inst., Insurer Responds to HIV Discrimination Complaint by Lowering Patient Costs for Drugs (Aug. 30, 2023), https://hivhep.org/press-releases/insurer-responds-to-hiv-discrimination-complaint-by-lowering-patient-costs-for-drugs/ [https://perma.cc/P9GC-JX24] (describing how filing discrimination complaints aided in causing insurance companies to drop adverse tiering practices); Luke Zarzecki, *Advocates Seek More Action on Adverse Tiering for HIV Treatments*, INSIDE HEALTH POL'Y (Feb. 13, 2024, at 18:43 PT), https://insidehealthpolicy.com/daily-news/advocates-seek-more-action-adverse-tiering-hiv-treatments [https://perma.cc/F9CD-7RWF] (advocating for increased enforcement of antidiscrimination laws).

Morbidity Structural Measure, which considers if a hospital or health system participated in a statewide or nationwide perinatal quality improvement collaborative program, and implemented evidence-based quality interventions in hospital settings to improve maternal health.[251] This award does not currently consider whether the hospital or health system has pending or adjudicated complaints of civil rights violations and/or reports of patients' poor experiences.[252] Notably, only 7% of the nation's hospitals with maternity units did not receive the birthing-friendly designation when the program first began in 2023.[253] Yet, if the vast majority of hospitals in this country were truly deserving of the birthing-friendly designation, the United States would not have such dismal maternal health outcomes. Awarding only the most deserving institutions such a designation would help incentivize hospitals to provide care worthy of this designation. Even worse, a federal agency bestowing such an endorsement upon an undeserving entity is misleading and harmful to patients who will trust such a government endorsement.

Before HHS designates or continues to designate a hospital or health system as "birthing friendly," it should consider whether the hospital or health system provides mechanisms for pregnant and postpartum patients to report instances of disrespect and mistreatment on the basis of race, ethnicity, or other characteristics. These patient reports should be considered in evaluating the appropriateness of the birthing-friendly designation. Additionally, the birthing-friendly designation should consider the percentage of providers who have received implicit bias, antiracism, and cultural humility training. All providers, even those who are not from or primarily serving underserved communities, could benefit from such trainings, which have demonstrated success in altering motivations and behaviors when coupled with "policies and procedures that support equity and inclusion."[254]

---

[251] Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2023 Rates, 87 Fed. Reg. 48780, 49282 (Aug. 10, 2022); *Maternal Morbidity Structural Measure*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/files/document/maternal-morbidity-structural-measure-specifications.pdf [https://perma.cc/NJT3-ZL6S] (last visited Jan. 12, 2026); *FY 2023 IPPS and LTCH PPS*, *supra* note 180.

[252] *FY 2023 IPPS and LTCH PPS*, *supra* note 180; *Maternal Morbidity Structural Measure*, *supra* note 251.

[253] Jessie Hellmann, *'Birthing Friendly' Label Requires Little Effort by Hospitals*, ROLL CALL (May 9, 2024, at 05:00 PT), https://rollcall.com/2024/05/09/birthing-friendly-label-requires-little-effort-by-hospitals/ [https://perma.cc/DRL6-UC3W]; NAT'L P'SHIP FOR WOMEN & FAMS., TRANSFORMING MATERNAL HEALTH IN MEDICAID 35 (2025), https://nationalpartnership.org/wp-content/uploads/transforming-maternal-health-in-medicaid-playbook.pdf [https://perma.cc/TPN8-5YLB] ("Most hospitals (2,225) with maternity units have received the birthing-friendly designation, and just 135 hospitals did not meet the criteria for receiving the designation.").

[254] Elizabeth Brondolo, Amandeep Kaur, Rebecca Seavey, Melissa Flores & Collaborative Health Integration Rsch. Program (CHIRP) DEI Writing Grp., *Anti-Racism Efforts in Healthcare:*

2. *Perverse Payment Incentives*

> *"I think caregivers are too quick to induce labor once a mother hits 39 weeks because it is more convenient for them. I think they are more concerned with their schedule than the health and well being of the mother and baby."*[255]

While many of the innovative delivery system models implemented under the ACA have improved continuity in care, efficiency in delivery, and led to better health outcomes, people of color have not benefited equally from these care coordination models.[256] Relatedly, the safety net providers who disproportionately serve people with low incomes often do not have the infrastructure and upfront capital needed to participate in these models.[257] CMMI should continue to adopt such models and ensure they include a range of providers such as safety net providers and midwives, as well as perinatal workers such as lactation consultants and doulas.

Even where CMMI has made investments in innovative care models, the agency has fallen short supporting implementation. For instance, the Strong Start Initiative, outlined above, also included a Maternity Care Home model.[258] This delivery system model was characterized by a single clinician providing or coordinating care, as well as quality improvement initiatives to improve continuity of care and focus on patient-centered care.[259] Within the Strong Start Initiative, the Maternity Care Home model did not result in improved birth outcomes or reduce costs—though maternity care homes outside of this initiative have demonstrated improved outcomes.[260] Provider and administrator participants in

---

A Selective Review From a Social Cognitive Perspective, 10 POL'Y INSIGHTS FROM BEHAV. & BRAIN SCIS. 160, 161 (2023).

[255] DECLERCQ ET AL., *supra* note 15, at 15.

[256] *See* William K. Bleser, Yolande Pokam Tchuisseu, Humphrey Shen, Andrea Thoumi, Chinmay Amin et al., *ACO REACH and Advancing Equity Through Value-Based Payment, Part 2*, HEALTH AFFS. FOREFRONT (May 18, 2022), https://www.healthaffairs.org/content/forefront/aco-reach-and-advancing-equity-through-value-based-payment-part-2 (on file with the Lewis & Clark Law Review); SINSI HERNÁNDEZ-CANCIO, ELLEN ALBRITTON, ELIOT FISHMAN & DENISSE SANCHEZ, FAMS. USA, A NATIONAL PRIORITY AGENDA TO ADVANCE HEALTH EQUITY THROUGH SYSTEM TRANSFORMATION: THE HEALTH EQUITY TASK FORCE FOR DELIVERY AND PAYMENT TRANSFORMATION'S TOP 19 RECOMMENDATIONS FOR 2019 AND BEYOND 7, 10 (2018), https://familiesusa.org/wp-content/uploads/2019/10/National-Priorities_Report.pdf [https://perma.cc/9EVV-X543].

[257] J. Mac McCullough, Natasha Coult, Michael Genau, Ajay Raikhelkar, Kailey Love & William Riley, *Safety Net Representation in Federal Payment and Care Delivery Reform Initiatives*, AM. J. ACCOUNTABLE CARE, Feb. 28, 2019, at 17, 17–18; *see* Jay Bhatia, Rachel Tobey & Michael Hochman, *Value-Based Payment Models for Community Health Centers: Time to (Cautiously) Take the Plunge?*, 317 JAMA 2275, 2275–76 (2017).

[258] HILL ET AL., *supra* note 171, at 5; *see supra* text accompanying notes 170–72.

[259] HILL ET AL., *supra* note 171, at 5.

[260] *Id.* at 5, 135; *see* TAYLOR ET AL., *supra* note 31, at 32–33 (showing improved outcomes in Wisconsin and North Carolina).

the Maternity Care Home model cited among its challenges that the CMMI award rollout did not allow for sufficient planning; the initiative did not fund start-up costs; insufficient stakeholder buy-in at all levels of the organization (from executives and managers to administrative staff); initial challenges in integrating peer counselors and care managers into the existing care structure; and health systems were ill-equipped to address psychosocial needs including substance abuse and mental health, transportation, housing and childcare needs, yet related program funds were not approved to address these concerns.[261]

Further, existing payment structures frequently incentivize higher-cost services that may benefit provider payments, not necessarily patients' health.[262] Despite decades of shifts towards managed care and more recent payment and delivery system reforms, insurers are still largely paying for quantity over quality in health care.[263] For private coverage, payment policies are mostly at the discretion of private insurers.[264] In the Medicaid program, states set the reimbursement rates and structures, which has led to significant variation across states.[265] CMS does provide guidance to states on setting reimbursement rates, particularly for Medicaid managed care, and the federal government plays an oversight role across the program.[266] However, it is not clear to what extent that provider payment information is systematically reported to the federal government—which by its nature, limits the federal government's ability to provide oversight and ensure payments are benefiting the health and well-being of Medicaid beneficiaries.[267] The information collected when states make changes to their provider payment systems is also not publicly available.[268]

---

[261] HILL ET AL., *supra* note 171, at 24–28, 133.

[262] *See Problems With Current Value-Based Payment Systems*, CTR. FOR HEALTHCARE QUALITY & PAYMENT REFORM, https://chqpr.org/VBP_Problems.html [https://perma.cc/VX5P-GE6F] (last visited Jan. 12, 2026).

[263] *Id.*

[264] *See id.*

[265] DEP'T OF HEALTH & HUM. SERVS., CTRS. FOR MEDICARE & MEDICAID SERVS., 2024–2025 MEDICAID MANAGED CARE RATE DEVELOPMENT GUIDE: FOR RATING PERIODS STARTING BETWEEN JULY 1, 2024 AND JUNE 30, 2025, at 32–33 (2024), https://www.medicaid.gov/media/169711 [https://perma.cc/23AM-CNRC]; Rhiannon Euhus & Jessica Mathers, *A Look at Variation in Medicaid Spending Per Enrollee by Group and Across States*, KFF (Oct. 6, 2025), https://www.kff.org/medicaid/a-look-at-variation-in-medicaid-spending-per-enrollee-by-group-and-across-states/ [https://perma.cc/VK5T-GHE6].

[266] *See, e.g.*, DEP'T OF HEALTH & HUM. SERVS., *supra* note 265, at 3, 5, 11.

[267] ROB NELB, MEDICAID & CHIP PAYMENT & ACCESS COMM'N, PROPOSED RECOMMENDATIONS FOR IMPROVING THE TRANSPARENCY OF MEDICAID FINANCING 4, 6 (2024), https://www.macpac.gov/wp-content/uploads/2024/03/01_March-Slides_Proposed-Recommendation-for-Improving-the-Transparency-of-Medicaid-Financing.pdf [https://perma.cc/P42L-6LHR].

[268] *Id.* at 4.

One problematic outcome of the payment structure is the U.S. C-section rate. The U.S. rate is more than double that which the World Health Organization (WHO) recommends.[269] While C-sections might be the best medical intervention for some women, the high rate suggests that it is being performed unnecessarily for some. C-sections also tend to be accompanied by higher reimbursement rates: Medicaid and commercial insurers pay an estimated 50% more for C-sections compared to vaginal deliveries.[270] C-sections can also be less time consuming than approaches to facilitate natural labor and vaginal delivery, and C-sections allow providers to schedule deliveries.[271] This surgery is also associated with increased risk for pregnancy complications, including infections, emergency hysterectomies, and maternal deaths.[272]

Other frequently unnecessary interventions are performed and reimbursed. Early elective deliveries, elective births before 39 weeks, are associated with an increased likelihood of anemia and infection.[273] Other sometimes unnecessary interventions are also common, including episiotomies, ultrasounds after 24 weeks,

---

[269] Since 1985, the World Health Organization has concluded that the "ideal rate" for C-sections is between 10–15%. World Health Organization [WHO], *Statement on Cesarean Section Rates*, at 2, WHO/RHR/15.02 (Apr. 14, 2015); *see also* World Health Organization [WHO], *Recommendations: Non-Clinical Interventions to Reduce Unnecessary Caesarean Sections*, at 12 (Oct. 11, 2018), https://iris.who.int/server/api/core/bitstreams/a38c497e-0617-4e5d-a950-7328926372fb/content [https://perma.cc/Z8RP-DYVX] (reiterating that the ideal rate for C-sections is between 10–15%, yet the rate in North America is approximately 32%).

[270] MEDICAID & CHIP PAYMENT & ACCESS COMM'N, MEDICAID PAYMENT INITIATIVES TO IMPROVE MATERNAL AND BIRTH OUTCOMES 1–2 (2019), https://www.macpac.gov/wp-content/uploads/2019/04/Medicaid-Payment-Initiatives-to-Improve-Maternal-and-Birth-Outcomes.pdf [https://perma.cc/43QV-WQ5T].

[271] *Id.*; Kukura, *supra* note 12, at 768–69 (noting that C-sections facilitate planning); *see* Tracy C. Bank, George Macones & Anthony Sciscione, *The "30-Minute Rule" for Expedited Delivery: Fact or Fiction?*, 28 AM. J. OBSTETRICS & GYNECOLOGY, at S1110, S1110–11 (2023) (noting that emergency C-section delivery is typically performed within 30 minutes).

[272] *C-Section Complications*, AM. PREGNANCY ASS'N (Mar. 13, 2024), https://americanpregnancy.org/healthy-pregnancy/labor-and-birth/c-section-complications/ [https://perma.cc/9DEW-EMG5].

[273] *See* Lindsay Allen & Daniel Grossman, *The Impact of Voluntary and Nonpayment Policies in Reducing Early-Term Elective Deliveries Among Privately Insured and Medicaid Enrollees*, 55 HEALTH SERV. RES. 63, 63 (2020) (discussing poor health outcomes generally); *Early Elective Delivery*, MATERNITY CARE PROJECT, https://maternitycareproject.com/early-elective-delivery/ [https://perma.cc/47GE-7XHN] (last visited Jan. 12, 2026) (explaining the increased risk for infection or emergency C-sections); *see also* Alemayehu Eshetu Hassen, Abatneh Feleke Agegnehu, Biruk Adie Admass & Mamaru Mollalign Temesgen, *Preoperative Anemia and Associated Factors in Women Undergoing Cesarean Section at a Comprehensive Specialized Referral Hospital in Ethiopia*, FRONTIERS MED., Apr. 4, 2023, at 1, 6 (finding that pregnant women who previously underwent C-sections were three times more likely to have anemia than those that had not).

and continuous electronic fetal monitoring.[274] Conversely, lower-cost preventive services, such as screenings and education, are frequently reimbursed at lower rates, if at all.[275]

Research has demonstrated that providers respond to financial incentives and pressures, even if subconsciously.[276] If providers are reimbursed for services not consistent with the standard of care, there is no financial incentive to provide better care. Relatedly, federal payment policies have not adequately incentivized desired care.[277] Illustratively, hospitals are not required to follow the AIM or PQC recommendations, even among the states and territories enrolled in the initiatives.[278] These are missed opportunities to tie payment to the quality of care and incentivize good behavior.

The federal government could better use its position as the largest payer to incentivize high-quality care. The ACA section 2702 provides that the Secretary "shall" identify state practices that "prohibit payment for health care-acquired conditions" and "incorporate the practices identified, or elements of such practices, which the Secretary determines appropriate for application to the Medicaid program in regulations."[279] Some states have adopted bundled payments or episode-based payments, where a provider is paid one fee for the services typically needed for an episode of care, which can decrease the incentive to deliver additional services for additional fees.[280] Similarly, some states will not pay for early elective deliveries, and this policy has reduced the rate of early elective deliveries and improved birth outcomes.[281] There is no such policy at the federal level.[282]

---

[274] *See* Kukura, *supra* note 12, at 768.

[275] Michelle H. Moniz, Vanessa K. Dalton & Elizabeth E. Krans, *The Cost of Preventive Care During Pregnancy: A Call to Action*, 31 WOMEN'S HEALTH ISSUES 511, 512 (2021).

[276] *See, e.g.*, Jeffrey Clemens & Joshua D. Gottlieb, *Do Physicians' Financial Incentives Affect Medical Treatment and Patient Health?*, 104 AM. ECON. REV. 1320, 1321–22 (2014); Brian S. Armour, M. Melinda Pitts, Ross Maclean, Charles Cangialose, Mark Kishel, Hirohisa Imai & Jeff Etchason, *The Effect of Explicit Financial Incentives on Physician Behavior*, 161 JAMA INTERNAL MED. 1261, 1261, 1263–64 (2001); Allen & Grossman, *supra* note 273, at 68.

[277] NAT'L ACADS. OF SCI., ENG'G & MED., ENDING UNEQUAL TREATMENT: STRATEGIES TO ACHIEVE EQUITABLE HEALTH CARE AND OPTIMAL HEALTH FOR ALL 152, 159 (Georges C. Benjamin, Jennifer E. DeVoe, Francis K. Amankwah & Sharyl J. Nass eds., 2024).

[278] *See Alliance for Innovation on Maternal Health (AIM)*, *supra* note 178.

[279] Patient Protection and Affordable Care Act § 2702, 42 U.S.C. § 1396b-1.

[280] Rajender Agarwal, Joshua M. Liao, Ashutosh Gupta & Amol S. Navathe, *The Impact of Bundled Payment on Health Care Spending, Utilization, and Quality: A Systematic Review*, 39 HEALTH AFFS. 50, 50–51 (2020).

[281] MEDICAID & CHIP PAYMENT & ACCESS COMM'N, *supra* note 270, at 4; Allen & Grossman, *supra* note 273, at 70.

[282] *See* MEDICAID & CHIP PAYMENT & ACCESS COMM'N, *supra* note 270, at 1 (noting that the federal government and other stakeholders are undertaking other, non-payment-based initiatives to improve maternal health).

Further, the statute reads that the regulations "shall prohibit payments" to state Medicaid programs for "health care-acquired conditions."[283] Currently, CMS regulations have a category of provider-preventable conditions including "wrong [s]urgical or other invasive procedure performed on a patient."[284] CMS should include early elective deliveries within the category of invasive procedures that the program will not reimburse. The Medicaid statute also provides the federal government authority to perform an oversight function over state Medicaid payments.[285] CMS could, pursuant to its oversight function, provide guidance to states on alternative payment models such as episode-based payments and the adoption of pay-for-performance models.

3. Maternity Workforce Shortage

> *"I had a patient who had diabetes. She drove one and a half hours each way to see me 16 times in her pregnancy because the local doctor wouldn't see her [due to the risk factors]. The burden on her was enormous. There is no question that distance poses a problem—and it results in a lot of patients not getting what they need."*[286]

> *"[D]octors are outside the community . . . there's a limit to their understanding and that limits the quality of care."*[287]

Over half of U.S. counties do not have an OBGYN, according to a 2017 study.[288] In 2018, only four midwives were available for every 1,000 births.[289] People living in rural areas experience these shortages most acutely: More than half of the women living in rural areas have to drive more than 30 minutes to a hospital with a maternity care unit.[290] Metropolitan areas have also seen a reduction in

---

[283] 42 U.S.C. § 1396b-1(a).

[284] Ctrs. for Medicare & Medicaid Servs., *Provider Preventable Conditions*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/financial-management/provider-preventable-conditions [https://perma.cc/5YSB-9PFA] (last visited Jan. 12, 2026).

[285] *See* 42 U.S.C. § 1396b-1.

[286] Amnesty International, *supra* note 14, at 64 (alteration in original).

[287] *Id.* at 25 (alteration in original).

[288] *ACOG Seeks to Expand Access, Increase Quality, and Improve Outcomes for Maternal Health in Rural Communities*, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS (June 3, 2020), https://www.acog.org/news/news-articles/2020/06/acog-seeks-to-expand-access-increase-quality-and-improve-outcomes-for-maternal-health-in-rural-communities [https://perma.cc/3X28-V527]; Linda Marsa, *Labor Pains: The OB-GYN Shortage*, ASS'N OF AM. MED. COLLS. (Nov. 15, 2018), https://www.aamc.org/news/labor-pains-ob-gyn-shortage [https://perma.cc/YW79-SUUK].

[289] Tikkanen et al., *supra* note 10.

[290] CHRISTINA BRIGANCE, RIPLEY LUCAS, ERIN JONES, ANN DAVIS, KATE MISHKIN, ZSAKEBA HENDERSON & MOTOKO OINUMA, MARCH OF DIMES, NOWHERE TO GO: MATERNITY CARE DESERTS ACROSS THE U.S. 11 (2022), https://www.marchofdimes.org/sites/default/files/2022-10/2022_Maternity_Care_Report.pdf [https://perma.cc/75JT-UZD6].

obstetric units within hospitals.[291] People of color and people with low incomes also tend to live in areas without sufficient availability of maternal health providers.[292] A long commute could make the difference in maternal health outcomes given the nature of labor and delivery and how quickly pregnancy complications can develop.[293]

There are several federal policies causing a maternity workforce shortage, but I focus here on two of the most salient.[294] First, there are barriers to education and training, particularly for people from marginalized communities. People from a community are more likely to return to serve that community,[295] but the high cost of medical education can keep people of color, people from rural communities, and people with low incomes from entering into the profession.[296] In turn, the low reimbursement rates can prevent these same people from returning to care for their own communities, particularly given providers who come from less affluent backgrounds are more likely to have outstanding student loan debt.[297]

---

[291] Staff Writer, *Maternity Ward Closures Exacerbating Health Disparities*, HARVARD T.H. CHAN SCH. OF PUB. HEALTH (Dec. 13, 2023), https://www.hsph.harvard.edu/news/features/maternity-obstetric-closure-health-disparities/ [https://perma.cc/C9XP-7D88].

[292] Nada Hassanein, *For Women of Color, Maternity Care Deserts Threaten Reproductive Health*, USC CTR. FOR HEALTH JOURNALISM (Feb. 8, 2022), https://centerforhealthjournalism.org/our-work/insights/women-color-maternity-care-deserts-threaten-reproductive-health [https://perma.cc/55JB-LKHZ]; *see* BRIGANCE ET AL., *supra* note 290, at 6–13.

[293] *See* Kukura, *supra* note 242, at 510–11 (noting reduced provider access can make it more difficult to find a provider who supports birthing needs and preferences, particularly a vaginal birth after a C-section or a vaginal birth for multiple babies, and can make it more difficult to find a provider who is culturally competent).

[294] The federal government has defined the maternal health workforce to include family medicine physicians, general internal medicine physicians, obstetrics and gynecology physicians (OBGYN), physicians specializing in neonatology or perinatal health, and nurse midwives, as well as registered nurses specializing in women's health or maternal/perinatal specialization. *State of the Maternal Health Workforce Brief*, NAT'L CTR. FOR HEALTH WORKFORCE ANALYSIS (Aug. 2022), https://www.cuny.edu/wp-content/uploads/sites/4/media-assets/maternal-health-workforce-brief-2022.pdf [https://perma.cc/CMN3-PZHS].

[295] For instance, providers who grew up in rural communities were more likely to return to rural communities to practice. Ian MacQueen, Melinda Maggard-Gibbons, Gina Capra, Laura Raaen, Jesus G. Ulloa et al., *Recruiting Rural Healthcare Providers Today: A Systematic Review of Training Program Success and Determinants of Geographic Choices*, 33 J. GEN. INTERNAL MED. 191, 191–192, 197 (2018). Additionally, a study among California physicians found that African Americans, Latinos, and Pacific Islanders were more likely to provide care in underserved communities and health professional shortage areas. Karen Odom Walker, Gerado Moreno & Kevin Grumbach, *The Association Among Specialty, Race, Ethnicity, and Practice Location Among California Physicians in Diverse Specialties*, 104 J. NAT'L MED. ASS'N 46, 49 (2012).

[296] Marc J. Kahn & Ernest J. Sneed, *Promoting the Affordability of Medical Education to Groups Underrepresented in the Profession: The Other Side of the Equation*, 17 AMA J. ETHICS 172, 172–173 (2015).

[297] *Id.* at 172, 174.

Second, low provider reimbursement rates can be a barrier to providers and other healthcare professionals entering the maternity care workforce. Medicaid, in particular, pays a lower amount for services delivered compared to other insurers.[298] Given Medicaid is the largest payer of maternity care, there is a direct connection between its rates and those willing and able to specialize in obstetrics.[299] Lower provider reimbursement rates, and subsequently, lower salaries associated with the maternal health workforce, can be a disincentive to provide care in certain areas.[300] In short, lower reimbursement rates run contrary to the other named HHS initiatives to expand the maternity care workforce. Given the income disparities for women of color, it follows that these women comprise a disproportionate share of Medicaid enrollees.[301] Subsequently, women of color face the most profound access issues resulting from Medicaid reimbursement rates.[302]

---

[298] *Provider Payment and Delivery Systems*, MEDICAID & CHIP PAYMENT & ACCESS COMM'N, https://www.macpac.gov/improved-101/provider-payment-and-delivery-systems/ [https://perma.cc/4HP9-MKCJ] (last visited Jan. 12, 2026).

[299] *Payment Parity for Obstetric Services*, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, https://www.acog.org/advocacy/policy-priorities/payment-parity-for-obstetric-services [https://perma.cc/L9RT-LB2R] (last visited Jan. 12, 2026); *see Births Financed by Medicaid by Metropolitan Status*, KFF, https://www.kff.org/improved/state-indicator/births-financed-by-medicaid/ [https://perma.cc/9DMR-VTAF] (last visited Jan. 12, 2026).

[300] Tiffany N. Ford & Jamila Michener, *Medicaid Reimbursement Rates Are a Racial Justice Issue*, COMMONWEALTH FUND (June 16, 2022), https://www.commonwealthfund.org/blog/2022/medicaid-reimbursement-rates-are-racial-justice-issue [https://perma.cc/VL57-THCU]; MEDICAID & CHIP PAYMENT & ACCESS COMM'N, PHYSICIAN ACCEPTANCE OF NEW MEDICAID PATIENTS: FINDINGS FROM THE NATIONAL ELECTRONIC HEALTH RECORDS SURVEY 1–2 (2021), https://www.macpac.gov/wp-content/uploads/2021/06/Physician-Acceptance-of-New-Medicaid-Patients-Findings-from-the-National-Electronic-Health-Records-Survey.pdf [https://perma.cc/3GKN-TXVZ]; *see also* Kayla Holgash & Martha Heberlein, *Physician Acceptance of New Medicaid Patients: What Matters and What Doesn't*, HEALTH AFFS. FOREFRONT (Apr. 10, 2019), https://www.healthaffairs.org/content/forefront/physician-acceptance-new-medicaid-patients-matters-and-doesn-t [https://perma.cc/99N6-2PA5] (noting that while OBGYNs accept new Medicaid patients at higher rates than the overall Medicaid acceptance rate, low Medicaid payment rates are a primary reason physicians decline to accept Medicaid patients).

[301] *See Medicaid Coverage by Race/Ethnicity: United States, 2021–2023 Average*, MARCH OF DIMES, https://www.marchofdimes.org/peristats/data?reg=99&top=11&stop=653&slev=1&obj=1 [https://perma.cc/7YQL-P8J3] (last visited Jan. 12, 2026); ANWESHA MAJUMDER & JESSCA MASON, NAT'L P'SHIP FOR WOMEN & FAMS., AMERICA'S WOMEN AND THE WAGE GAP 1 (2025), https://nationalpartnership.org/wp-content/uploads/2023/02/americas-women-and-the-wage-gap.pdf [https://perma.cc/EY47-W9CA] (documenting the gender wage gap).

[302] Ford & Michener, *supra* note 300; *see also* Ruqaiijah Yearby, Brietta Clark & José F. Figueroa, *Structural Racism in Historical and Modern US Health Care Policy*, 41 HEALTH AFFS. 187, 190–191 (2022) (explaining that low Medicaid reimbursement rates limit provider participation which exacerbates racial disparities in access to maternal health care); AYAN GORAN, LAURA TATUM, CARA BRUMFIELD & AILEEN CARR, GEORGETOWN CTR. ON POVERTY & INEQUALITY, RE-ENVISIONING MEDICAID & CHIP AS ANTI-RACIST PROGRAMS 10 (2023),

To make matters worse, OBGYNs increasingly report a hesitancy to practice in states with abortion restrictions for fear of criminal or civil prosecution—a problem even more acute for providers of color who come from overly-policed communities.[303] Relatedly, states are increasingly being allowed to limit people's access to family planning providers if these providers also provide abortions.[304] Following the COVID-19 pandemic, more healthcare professionals report experiencing burnout,[305] and this impact is felt even more among already overstretched provider specialties such as obstetrics and gynecology.[306] Providers who feel forced to move from patient to patient quickly without being able to fully understand problems or explain medical recommendations are more likely to make mistakes.[307]

Not only are there not enough providers and birthing support available, but the maternal health workforce also lacks diversity. Illustratively, 10.9% of OBGYNs are non-Hispanic Black or African American, 0.4% are Indigenous, 11.8% are Asian, and 7.6% are Hispanic, based on 2018 data.[308] Subsequently, Black adults are significantly less likely, compared to their white counterparts, to report having a usual provider with the same racial identity.[309] Notably, 80% of U.S. doulas and

---

https://www.georgetownpoverty.org/wp-content/uploads/2023/06/Re-envisioning-Medicaid-CHIP-June2023.pdf [https://perma.cc/H6RP-CPPD] (noting that low Medicaid reimbursement contributes to provider shortages and reduced access to healthcare in underserved communities).

[303] Stacy Weiner, *The Fallout of Dobbs on the Field of OB-GYN*, ASS'N OF AM. MED. COLLS. (Aug. 23, 2023), https://www.aamc.org/news/fallout-dobbs-field-ob-gyn [https://perma.cc/JXN5-MX3J].

[304] Medina v. Planned Parenthood S. Atl., 145 S. Ct. 2219, 2254 (2025) (holding that Medicaid beneficiaries do not have a private right to enforce the Medicaid freedom of choice provision; this ruling permitted the State of South Carolina to move forward with removing certain family planning providers from their Medicaid program).

[305] *Health Workers Face a Mental Health Crisis*, CTRS. FOR DISEASE CONTROL & PREVENTION: VITAL SIGNS (Oct. 24, 2023), https://www.cdc.gov/vitalsigns/health-worker-mental-health/index.html [https://perma.cc/GHH5-LNQU] (documenting a survey conducted following the COVID-19 pandemic finding that 46% of health workers reported feeling often burned out).

[306] Eman Haidari, Elliot K. Main, Xin Cui, Valerie Cape, Daniel S. Tawfik et al., *Maternal and Neonatal Health Care Worker Well-Being and Patient Safety Climate Amid the COVID-19 Pandemic*, 41 J. PERINATOLOGY 961, 962–63 (2021) (documenting a survey conducted during the COVID-19 pandemic that found 73% of maternal health care workers reported increased worker burnout and 66% of maternal health care workers reported personal emotional exhaustion).

[307] *See* Armour et al., *supra* note 276, at 1262–63.

[308] *State of the Maternal Health Workforce Brief*, *supra* note 294.

[309] Twenty-two percent of Black adults compared to 74% of white adults report having a usual provider with the same racial identity. DULCE GONZALEZ, GENEVIEVE M. KENNEY, MARLA MCDANIEL & CLAIRE O'BRIEN, URB. INST., RACIAL, ETHNIC, AND LANGUAGE CONCORDANCE BETWEEN PATIENTS AND THEIR USUAL HEALTH CARE PROVIDERS 2–3 (2022),

nearly 85% of midwives are white, which can impact the decisions of patients of color to use these professionals.[310] Without a sufficient supply of providers and birthing support, especially those with cultural competency, birthing people will not get needed care.

The history of distress and discrimination has led some patients to prefer to receive care from providers who have a shared identity, and racial and ethnic concordance between patient-provider identity has been associated with improved health outcomes.[311] Specifically, a provider who shares the same race or language has been associated with an increased likelihood of patients receiving preventive care,[312] and shared gender and race has been associated with improved mortality rates in hospital settings[313] and higher patient experience ratings.[314] These studies suggest having a provider with a shared identity can foster better trust, particularly for people of color who have been neglected, experimented upon, and abused in the U.S. healthcare system.[315] LGBTQIA people, particularly those who are nonbinary

---

https://www.urban.org/sites/default/files/2022-03/racial-ethnic-and-language-concordance-between-patients-and-providers.pdf [https://perma.cc/AQ9A-UMZH].

[310] MATHILDE ROUX, U.S. DEP'T OF LAB.: WOMEN'S BUREAU, EXPANDING AND DIVERSIFYING THE DOULA WORKFORCE: CHALLENGES AND OPPORTUNITIES OF INCREASING INSURANCE COVERAGE 2 (2023), https://www.dol.gov/sites/mprov/files/WB/Wbissuebrief-doulas-v3.pdf [https://perma.cc/Y2TP-JD5S]; AM. MIDWIFERY CERTIFICATION BD., 2021 DEMOGRAPHIC REPORT 1–2 (2021), https://www.amcbmidwife.org/docs/default-source/reports/demographic-report-2021.pdf?sfvrsn=cac0b1e8_2 [https://perma.cc/47K8-JN29]; Kristen Wint, Thistle I. Elias, Gabriella Mendez & Tiffany L Gary-Webb, *Experiences of Community Doulas Working with Low-Income, African American Mothers*, 3 HEALTH EQUITY 109, 114 (2019).

[311] Carrington Moore, Erica Coates, Ar'Reon Watson, Rebecca de Heer, Alison McLeod & Arielle Prudhomme, "*It's Important to Work with People that Look Like Me": Black Patients' Preferences for Patient-Provider Race Concordance*, 10 J. RACIAL & ETHNIC HEALTH DISPARITIES 2552, 2552 (2023); *see also* Megan Johnson Shen, Emily B. Peterson, Rosario Costas-Muñiz, Migda Hunter Hernandez, Sarah T. Jewell, Konstantina Matsoukas & Carma L. Bylund, *The Effects of Race and Racial Concordance on Patient-Physician Communication: A Systematic Review of the Literature*, 5 J. RACIAL & ETHNIC HEALTH DISPARITIES 117, 136–37 (2018) (finding that racial concordance between physicians and patients is a consistent predictor of better patient-physician communication).

[312] GONZALEZ ET AL., *supra* note 309, at 1; Hector M. González, William A. Vega & Wassim Tarraf, *Health Care Quality Perceptions Among Foreign-Born Latinos and the Importance of Speaking the Same Language*, 23 J. AM. BD. FAM. MED. 745, 748 (2010).

[313] Andrew J. Hill, Daniel B. Jones & Lindsey Woodworth, *Physician-Patient Race-Match Reduces Patient Mortality*, J. HEALTH ECON., Oct. 4, 2023, at 1, 2.

[314] Junko Takeshita, Shiyu Wang, Alison W. Loren, Nandita Mitra, Justine Shults, Daniel B. Shin & Deidre L. Sawinski, *Association of Racial/Ethnic and Gender Concordance Between Patients and Physicians with Patient Experience Ratings*, JAMA NETWORK, Nov. 9, 2020, at 1, 9–10; Sonia V. Otte, *Improved Patient Experience and Outcomes: Is Patient–Provider Concordance the Key?*, J. PATIENT EXPERIENCE, May 29, 2022, at 1, 4.

[315] Takeshita et al., *supra* note 314, at 9.

and transgender, also report that having someone who shares their identity increased feelings of inclusion and reduced the likelihood of being misgendered.[316]

As explained above, the Secretary, through HRSA, is authorized to address perinatal health disparities, and this authority could continue to be used to expand the maternal health workforce.[317] HRSA Maternal Health Workforce Programs train new certified nurse midwives and community-based doulas through the Healthy Start Initiative.[318] These programs should be extended to also train community-based midwives, who provide care outside of the hospital setting at homes or birth centers, and maternal mental and behavioral health care providers. Additionally, multi-year funding should again be awarded to train community-based doulas with a focus on improving maternal health outcomes, particularly eliminating racial and ethnic health disparities. Community-based midwives and doulas often have connections to their patients and can understand the current and historical context in which health needs arise.[319]

The Social Security Act also requires the Medicaid program to ensure reimbursement rates are sufficient to provide reasonable access to services, and in practice, compliance with this requirement has largely been left to the states.[320] CMS should use its oversight authority to ensure Medicaid payment rates are sufficient to provide reasonable access for patients. States should be required to, and held accountable for, regularly and systematically reporting on reimbursement rates. This information should then be used to assess compliance with the statutory obligations. CMS should ensure there is parity in rates for midwives consistent with their education and experience level. Reimbursement rates should also ensure access to birthing support, including doulas and lactation consultants.

4. Limited Provider Networks

"I would have chosen a midwife if that were an option. There are none available where I live under my insurance plan."[321]

Exacerbating the maternity care workforce shortage, the available providers and perinatal support might not be covered within a person's insurance network. Birthing people have already been deprived of the birthing support of their choice. Birthing people have been coerced to deliver in a hospital, even if the desire is to labor at home or in a freestanding birth center.[322] Similarly, it is not uncommon for

---

[316] ELLMANN, *supra* note 17, at 9, 14.

[317] *See supra* notes 182–85 and accompanying text.

[318] *See* HEALTH RES. & SERVS. ADMIN., HRSA-22-148, *supra* note 186 (describing how to apply for Healthy State Initiative grant funds).

[319] *See* ELLMANN, *supra* note 17, at 2–4.

[320] *See* Social Security Act § 1900, 42 U.S.C. § 1396.

[321] DECLERCQ ET AL., *supra* note 15, at 6.

[322] Borges, *supra* note 49, at 842–43, 851.

pressure to be applied to use a physician for childbirth and prenatal needs when a person might believe a midwife is best for their pregnancy and delivery.[323] Further, insurance coverage for certain midwives, particularly community-based and certified professional midwives, is more limited than physician coverage.[324] Some women and birthing people prefer to receive their medical care from a midwife, as opposed to a physician, and midwives have been associated with improved health outcomes.[325]

Also, private insurers largely do not cover doula services, so most birthing people must pay out-of-pocket to use those services.[326] Many who use a doula credit their services with helping them execute their own birth plan and improving patient autonomy.[327] Multiple studies have even associated the use of a doula with lower maternal health complications, reduced C-sections and other medical interventions, and higher breastfeeding rates.[328] Without adequate insurance coverage, the ability to use a doula frequently becomes an option only for people who can afford to pay out-of-pocket.[329]

---

[323] *See id.* at 855 (arguing that sexist views of the pregnant female body are the root of many instances of obstetric violence, including "a decrease in unassisted birth and a formal subjugation of doulas and midwives to obstetricians").

[324] *See* ELLMANN, *supra* note 17, at 15; Nora Ellmann & Jamille Fields Allsbrook, *States' Essential Health Benefits Coverage Could Advance Maternal Health Equity*, CTR. FOR AM. PROGRESS (Apr. 30, 2021), https://www.americanprogress.org/article/states-essential-health-benefits-coverage-advance-maternal-health-equity/ [https://perma.cc/KV4D-KJTP]; MEDICAID & CHIP PAYMENT & ACCESS COMM'N, ACCESS TO MATERNITY PROVIDERS: MIDWIVES AND BIRTH CENTERS 2, 5–6 (2023), https://www.macpac.gov/wp-content/uploads/2023/05/Access-to-Maternity-Providers-Midwives-and-Birth-Centers.pdf [https://perma.cc/7YUZ-ZKWK].

[325] Katy B. Kozhimannil, Laura Attanasio & Fernando Alarid-Escudero, *More Midwife-Led Care Could Generate Cost Savings and Health Improvements*, UNIV. OF MINN. SCH. OF PUB. HEALTH (Nov. 2019), https://www.sph.umn.edu/sph/wp-content/uploads/docs/policy-brief-midwife-led-care-nov-2019.pdf [https://perma.cc/X3JB-MR79].

[326] Amy Chen & Kate Rohde, *Private Insurance Coverage of Doula Care: A Growing Movement to Expand Access*, NAT'L HEALTH L. PROGRAM (Mar. 14, 2023), https://healthlaw.org/private-insurance-coverage-of-doula-care-a-growing-movement-to-expand-access-2 [https://perma.cc/H6EP-E8LF] (stating coverage of doula services in private insurance plans is "nearly nonexistent").

[327] *See* ALEXANDRIA SOBCZAK, LAUREN TAYLOR, SYDNEY SOLOMON, JODI HO, SCOTLAND KEMPER ET AL., THE EFFECT OF DOULAS ON MATERNAL AND BIRTH OUTCOMES: A SCOPING REVIEW 5 (2023), https://assets.cureus.com/uploads/review_article/pdf/154723/20250923-123621-tezoeq.pdf [https://perma.cc/R7DN-HBDA] (finding that women who used doulas during childbirth reported that doulas raised feelings of confidence and autonomy during labor).

[328] *See* KATHLEEN KNOCKE, ANDRE CHAPPEL, SARAH SUGAR, NANCY DE LEW & BENNJAMIN D. SOMMERS, OFF. OF THE ASSISTANT SEC'Y FOR PLAN. & EVALUATION, OFF OF HEALTH POL'Y, DOULA CARE AND MATERNAL HEALTH: AN EVIDENCE REVIEW 5 (2022), https://aspe.hhs.gov/sites/default/files/documents/dfcd768f1caf6fabf3d281f762e8d068/ASPE-Doula-Issue-Brief-12-13-22.pdf [https://perma.cc/HU8H-P5A6].

[329] Wint et al., *supra* note 310, at 114 ("[C]ost is the greatest barrier to doula services, with doula support traditionally limited to birthing persons with the financial means to hire them. As

A lack of insurance coverage can also be a barrier for those seeking to move their births outside of the hospital setting.[330] The COVID-19 pandemic, like prior public health crises such as the severe acute respiratory syndrome (SARs), H1N1, and influenza outbreaks, increased the desire among birthing people to deliver outside of the hospital setting, demonstrating the need for access to home births and freestanding birth centers.[331] Even still, the increased desire for out-of-hospital births did not start or end with the COVID-19 pandemic, but instead seems to be driven by a desire to have less medicalized births.[332] This desire has been particularly pronounced among marginalized communities where there is frequently mistrust in the medical system.[333]

The ACA network adequacy standards are not defined in statute with precision, as explained above, which has allowed for significant variations in providers and perinatal workers within plan networks.[334] HHS should maintain a federal minimum standard to ensure network adequacy standards include quantitative standards, such as time and distance requirements, wait times, and patient-to-enrollee ratios. The existing time-and-distance and appointment-wait-time standards for obstetric and gynecological services should include doula and midwifery services. Coverage should extend to non-hospital births including freestanding birth centers and home births. The ACA does require plans

---

a result, doula care has come to be viewed as a privilege reserved for wealthy, white people capable of paying for the resource.").

[330] Tara Law, *Home Births Became More Popular During the Pandemic. But Many Insurers Still Don't Cover Them*, TIME (Feb. 11, 2022, at 08:00 EST), https://time.com/6145726/home-births-insurance-coverage/ [https://perma.cc/EB4B-84AW].

[331] Kaia Hubbard, *Pandemic Propels Interest in Out-of-Hospital Births*, U.S. NEWS & WORLD REP.: HEALTH NEWS (Mar. 4, 2021), https://www.usnews.com/news/health-news/articles/2021-03-04/pandemic-propels-interest-in-home-out-of-hospital-births [https://perma.cc/3LUX-MPC5]; JAMILLE FIELDS ALLSBROOK, CTR. FOR AM. PROGRESS, THE CORONAVIRUS CRISIS CONFIRMS THAT THE U.S. HEALTH CARE SYSTEM FAILS WOMEN 7 (2020), https://www.americanprogress.org/wp-content/uploads/sites/2/2020/04/FieldsWomensHealth-brief.pdf [https://perma.cc/3PSX-64QT].

[332] Marian F. MacDorman & Eugene Declercq, *Trends and State Variations in Out-of-Hospital Births in the United States, 2004–2017*, 46 BIRTH 279, 286–87 (2019).

[333] *See* Mohsen Bazargan, Sharon Cobb & Shervin Assari, *Discrimination and Medical Mistrust in a Racially and Ethnically Diverse Sample of California Adults*, 19 ANNALS FAM. MED. 4, 9–11 (2021) (reporting a study demonstrating the mistrust of healthcare professionals among minority communities).

[334] Karen Pollitz, *Network Adequacy Standards and Enforcement*, KFF (Feb. 4, 2022), https://www.kff.org/affordable-care-act/network-adequacy-standards-and-enforcement/ [https://perma.cc/HAC7-J8BB]. *See generally Health Insurance Network Adequacy Requirements*, NAT'L CONF. OF STATE LEGISLATURES (June 1, 2023), https://www.ncsl.org/health/health-insurance-network-adequacy-requirements (on file with the Lewis & Clark Law Review) (outlining the different state standards governing provider access); *see supra* text accompanying notes 192–93.

participating in the Medicaid program to cover provider services performed at freestanding birth centers, but this requirement does not apply to private plans.[335] To enforce existing requirements, HHS should maintain robust federal oversight for federal and state marketplaces including monitoring provider directories and providing a template provider directory with an option for providers to note their race and ethnicity. Plans offered on the federally facilitated marketplaces are required to update directories monthly, but there have been numerous studies from both within and outside of the government finding inaccuracies.[336] This suggests that more uniformity in oversight is needed.

HHS should also issue regulations pursuant to the ACA section 2706, ensuring that providers cannot be discriminated against or excluded from health plans solely for providing family planning services, including abortion; and that providers, including midwives, receive comparable pay for providing the same services as other providers.[337] Midwives are often paid significantly less than providers for delivering the same services.[338] This inequity limits access to these providers. Further, women frequently rely upon family planning providers as their regular source of care.[339] States and the federal government have tried to exclude these providers from Medicaid, Title X and the Teen Pregnancy Prevention Program.[340] Regulations under the ACA will not prevent these attempts to remove family planning providers from other programs, but they can set a minimum standard that private insurers must adhere to regardless of state politics.

---

[335] Patient Protection and Affordable Care Act § 2301, 42 U.S.C. §1396d(a)(28).

[336] *E.g.*, AM. MED. ASS'N & COUNCIL FOR AFFORDABLE QUALITY HEALTH CARE, IMPROVING HEALTH PLAN PROVIDER DIRECTORIES: AND THE NEED FOR HEALTH PLAN-PRACTICE ALIGNMENT, AUTOMATION AND STREAMLINED WORKFLOWS 2–5 (2021), https://www.ama-assn.org/system/files/improving-health-plan-provider-directories.pdf [https://perma.cc/T7VT-J7VH].

[337] *See* 42 U.S.C. § 300gg-5.

[338] Brigette Courtot, Ian Hill, Caitlin Cross-Barnet & Jenny Markell, *Midwifery and Birth Centers Under State Medicaid Programs: Current Limits to Beneficiary Access to a High-Value Model of Care*, 98 MILBANK Q. 1091, 1101–02 (2020).

[339] Jennifer J. Frost, Rachel Benson Gold & Amelia Bucek, *Specialized Family Planning Clinics in the United States: Why Women Choose Them and Their Role in Meeting Women's Health Care Needs*, 22 WOMEN'S HEALTH ISSUES, at e519, e522 (2012).

[340] *See* Kari White, Samuel L. Dickman, Julia Strasser & Hannah Simons, *The Risks of Excluding Qualified Family Planning Providers from Medicaid*, 334 JAMA 857, 857–58 (2025); Kinsey Hasstedt, *Recent Funding Restrictions on the U.S. Family Planning Safety Net May Foreshadow What Is to Come*, 19 GUTTMACHER POL'Y REV. 67, 69 (2016); Brittni Frederiksen, Usha Ranji & Alina Salganicoff, *Major Federal and State Funding Cuts Facing Planned Parenthood*, KFF (May 15, 2025), https://www.kff.org/womens-health-policy/major-federal-and-state-funding-cuts-facing-planned-parenthood/ [https://perma.cc/5H3A-FWBV].

5. *Health Insurers Not Covering Wanted and Needed Care*

"After 7 days I still needed hospital care, but because I was on Medicaid, I had to be dismissed. My doctor got me back in the hospital a few days after my dismissal so my high blood pressure medication could be regulated."[341]

Childbirth is one of the most expensive health care services, and the costs are increasing.[342] Over 40% of people have medical debt, and of the women under 30 with medical debt, their debt resulted from childbirth.[343] Women are generally more likely to report problems paying for medical bills and costs have led them to delay or forgo care.[344] Therefore, women are even more responsive to insurance policies that support or impede their care decisions.[345] Without access to coverage, people may forgo or delay necessary and preventive care.[346]

Health insurance plans might not adequately cover needed or preferred health care services and may not cover services under the birthing circumstances the person desires. As explained, the ACA requires individual and small group plans to cover maternity and newborn care, but states have been allowed to select what specific services are included under this benefit.[347] Specifically, HHS has allowed states to

---

341 DECLERCQ ET AL., *supra* note 15, at 49.

342 *See* Alejandra O'Connell-Domenech, *Giving Birth is Pricey in the US, and Growing Pricier*, THE HILL: CHANGING AM. (Oct. 22, 2023), https://thehill.com/changing-america/well-being/4265540-giving-birth-is-pricey-in-the-us-and-growing-pricier/ [https://perma.cc/V4VV-NXTY]; Elisabeth Rosenthal, *American Way of Birth, Costliest in the World*, N.Y. TIMES (June 30, 2013), https://www.nytimes.com/2013/07/01/health/american-way-of-birth-costliest-in-the-world.html [https://perma.cc/QL86-HT8B].

343 Lunna Lopes, Audrey Kearney, Alex Montero, Liz Hamel & Mollyann Brodie, *Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills*, KFF (June 16, 2022), https://www.kff.org/health-costs/kff-health-care-debt-survey/#c7f7c77b-dec4-4baf-bed1-78e3522b4f46 [https://perma.cc/FR7S-UD7A].

344 *Id.*

345 Michelle Long, Brittni Frederiksen, Usha Ranji, Alina Salganicoff & Karen Diep, *Experiences with Health Care Access, Cost, and Coverage: Findings From the 2022 KFF Women's Health Survey*, KFF (Dec. 20, 2022), https://www.kff.org/womens-health-policy/experiences-with-health-care-access-cost-and-coverage-findings-from-the-2022-kff-womens-health-survey/ [https://perma.cc/3XTK-Y3VT].

346 Jennifer Tolbert, Sammy Cervantes, Clea Bell & Anthony Damico, *Key Facts About the Uninsured Population*, KFF (Dec. 18, 2024), https://www.kff.org/uninsured/key-facts-about-the-uninsured-population/ [https://perma.cc/WV9A-9G57].

347 AMY CHEN & EMILY HAYES, NAT'L HEALTH L. PROGRAM, Q&A ON PREGNANT WOMEN'S COVERAGE UNDER MEDICAID AND THE ACA 4 (2018), https://healthlaw.org/resource/qa-on-pregnant-womens-coverage-under-medicaid-and-the-aca/ [https://perma.cc/ZP9N-E5X2]; *see* Michelle Samuels, *Medicaid-Covered Mothers Have Less Say in Birthing Experience*, BOS. UNIV. SCH. OF PUB. HEALTH (July 27, 2020), https://www.bu.edu/sph/news/articles/2020improved-covered-mothers-have-less-say-in-birthing-experience/ [https://perma.cc/46FJ-FSEN] (noting that after adjusting for demographics and health conditions, a mother on Medicaid is three times less likely than a mother on private

select a benchmark plan which sets the minimum services, frequency, and duration for private insurers subject to this coverage requirement.[348] An assessment of state benchmark plans concluded that the benchmark approach has allowed uneven coverage for pregnancy and maternity services throughout the country.[349] This study found states vary significantly in coverage of prenatal and labor and delivery services, home health visiting, and breastfeeding services and supplies, as well as to what extent labor and delivery are covered if delivered at a home or freestanding birth center.[350]

The ACA notes that "the Secretary shall define the essential health benefits."[351] This statute is not only clear authorization for the Secretary to further define the EHBs but a requirement for the Secretary to do so.[352] The statute also provides a number of clear directives to the Secretary regarding this benefit: HHS has a duty to periodically assess and update the EHB standard accordingly "to address any gaps in access to coverage or changes in the evidence base."[353] If the Secretary were to perform its task to assess plans' compliance with the EHBs, it would quickly realize the well-documented variations in coverage, which suggest Congress' intent to standardize benefits is not being met.[354] Further, the evidence base around our understanding of the root causes driving maternal health inequities has evolved.[355] The Secretary must also "take into account the health care needs of diverse segments of the population, including women," amongst others.[356] There has been robust evidence proving the disproportionate impact these coverage gaps have on women, particularly women of color, women with low incomes, and women living in rural areas, of which the statute requires the Secretary to take account.[357] Even more, the Secretary has used the EHB authority

insurance to feel she had a choice about whether she had a vaginal or cesarean birth, or an episiotomy); *supra* notes 206–08 and accompanying text.

[348] CHEN & HAYES, *supra* note 347, at 9.

[349] Ellmann & Allsbrook, *supra* note 324.

[350] *Id.*

[351] Patient Protection and Affordable Care Act § 1302, 42 U.S.C. § 18022(b)(1); *see also* CTRS. FOR CONSUMER INFO. & INS. OVERSIGHT, ESSENTIAL HEALTH BENEFITS BULLETIN 1, 8–9 (2011), https://www.cms.gov/cciio/resources/files/downloads/essential_health_benefits_bulletin.pdf [https://perma.cc/MS8F-QNFJ] (summarizing and soliciting comments on the "regulatory approach" of HHS in defining EHBs under this statute).

[352] 42 U.S.C. § 18022(b)(4).

[353] *Id.* § 18022(b)(4)(G)–(H).

[354] Ellmann & Allsbrook, *supra* note 324.

[355] *See* Monica H. Keith & Melanie A. Martin, *Social Determinant Pathways to Hypertensive Disorders of Pregnancy Among Nulliparous US Women*, 34 WOMEN'S HEALTH ISSUES 36, 36, 42 (2024).

[356] 42 U.S.C. § 18022(b)(4)(C).

[357] Laura Harker, *Closing Coverage Gap a Crucial Step for Health Equity in Rural Communities of Color*, CTR. ON BUDGET & POL'Y PRIORITIES (Oct. 4, 2021, at 14:45 PT),

to set a minimum threshold for habilitative services and prescription drugs, demonstrating the statutory authority to set minimum standards for EHB services.[358]

However, over three presidential administrations, HHS has failed to define the requirement and has largely deferred to the states to identify the specific services that must be covered.[359] This is contrary to congressional intent to create uniformity in the benefits covered.[360] HHS originally reasoned that there were "no systematic difference[s] in the breadth of services" offered among plans—a fact that has either changed or been proven untrue since 2011 when it was first offered.[361] HHS also initially stated it would regularly reassess the benchmark process.[362] It has been over a decade since the initial regulatory approach was adopted, and the time has come to reassess the benchmark process.[363]

The Secretary should promulgate a regulation that articulates a national EHB standard, noting specific inclusions and exclusions. Regarding maternal health, this standard should include an enumerated list of services and education, the frequency with which these services must be covered, the conditions under which these services must be covered—such as pregnancy, false pregnancy, miscarriage, or abortion—and any permitted exclusions. These recommendations should be consistent with, but not limited to, ACOG and the American Academy of Pediatrics clinical

---

https://www.cbpp.org/blog/closing-coverage-gap-a-crucial-step-for-health-equity-in-rural-communities-of-color [https://perma.cc/Q8VW-JAF3]; *see* Ellmann & Allsbrook, *supra* note 324.

[358] *See* 45 C.F.R. §§ 156.115(a)(5), 156.122(a)(1) (2025).

[359] Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025, 89 Fed. Reg. 26218, 26233 (Apr. 15, 2024) (regulation under Biden); Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16930, 16930 (Apr. 17, 2018) (regulation under Trump); Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, 78 Fed. Reg. 12834, 12834–35 (Feb. 25, 2013) (regulation under Obama); *see also Information on Essential Health Benefits (EHB) Benchmark Plans*, *supra* note 209 (explaining the current EHB regulatory scheme); CTRS. FOR CONSUMER INFO. & INS. OVERSIGHT, *supra* note 351, at 5 (explaining that certain benefits in employee plans vary from state to state).

[360] *But see* Nicholas Bagley & Helen Levy, *Essential Health Benefits and the Affordable Care Act: Law and Process*, 39 J. HEALTH POL., POL'Y & L., 441, 451–53 (2014) (explaining the EHB benchmark approach would likely be upheld if challenged).

[361] *See* CTRS. FOR CONSUMER INFO. & INS. OVERSIGHT, *supra* note 351, at 5.

[362] *Id.* at 13.

[363] *See* Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 77 Fed. Reg. 70644, 70649 (Nov. 26, 2012) (to be codified at 45 C.F.R. pts. 147, 155 & 156) ("We propose that the state's benchmark plan selection in 2012 would be applicable for the 2014 and 2015 benefits years, and be based on plan benefits offered by the selected benchmark at the time of the selection, including any applicable state-required benefits enacted prior to December 31, 2011. We intend to revisit this policy for subsequent years.").

guidelines.[364] These services should also afford access to traditional birthing practices including non-hospital births in the home and freestanding birth centers, as well as services doulas and midwives provide. Additionally, childbirth education courses should be among the services covered.[365] Childbirth education courses are frequently not covered under insurance.[366] Childbirth education courses can provide birthing people information on the range of health care options, including the birth settings available, benefits and risks of common procedures, comfort techniques, and methods to avoid unnecessary interventions and medications, and can assist birthing people with developing a birthing plan that works for them.[367] These courses have also been associated with numerous positive outcomes such as a reduced number of additional medical interventions, higher rates of breastfeeding, and greater confidence and an enhanced sense of empowerment in making pregnancy-related decisions.[368]

Under the women's preventive services benefit, HHS has also limited the requirement to cover contraceptives by only requiring coverage for contraceptives with a prescription.[369] This means that plans do not have to cover over-the-counter contraceptives, including emergency contraceptives and the over-the-counter birth control pill.[370] HHS can require insurers to cover over-the-counter contraceptives, and the full range of breastfeeding services and supplies including manual, battery operated, and electric breast bumps. The Biden Administration proposed a

---

[364] *See Clinical Search Results*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS: CLINICAL, https://www.acog.org/clinical/clinical-guidance/clinical-practice-guideline [https://perma.cc/6ELW-78E5] (last visited Jan. 13, 2026); *Guidelines*, AM. MED. ASS'N: ED HUB, https://edhub.ama-assn.org/collections/5672/guidelines [https://perma.cc/L2GT-9D9V] (last visited Jan. 13, 2026).

[365] *See* Ellmann & Allsbrook, *supra* note 324.

[366] USHA RANJI, IVETTE GOMEZ, ALINA SALGANICOFF, CARRIE ROSENZWEIG, REBECCA KELLENBERG & KATHY GIFFORD, KFF, MEDICAID COVERAGE OF PREGNANCY-RELATED SERVICES: FINDINGS FROM A 2021 STATE SURVEY 8 (2022), https://files.kff.org/attachment/Report-Medicaid-Coverage-of-Pregnancy-Related-Services-Findings-from-a-2021-State-Survey.pdf [https://perma.cc/7WTD-YM6S].

[367] *See Childbirth Education Classes*, AM. PREGNANCY ASS'N, https://americanpregnancy.org/healthy-pregnancy/labor-and-birth/childbirth-education-classes/ [https://perma.cc/YVT7-UXYU] (last visited Jan. 13, 2026).

[368] Colleen G. Mueller, Pamela J. Webb & Stephanie Morgan, *The Effects of Childbirth Education on Maternity Outcomes and Maternal Satisfaction*, 29 J. PERINATAL EDUC. 16, 20–21 (2020); *see Childbirth Education Classes*, *supra* note 367.

[369] Nora V. Becker, *The Impact of Insurance Coverage on Utilization of Prescription Contraceptives: Evidence from the Affordable Care Act*, 37 J. POL'Y ANALYSIS & MGMT. 571, 572 (2018).

[370] *Id.*; *see also* Press Release, Food & Drug Admin., FDA Approves First Nonprescription Daily Contraceptive (July 13, 2023), https://www.fda.gov/news-events/press-announcements/fda-approves-first-nonprescription-daily-oral-contraceptive [https://perma.cc/TNL6-9BRT] (announcing FDA approval of the first over-the-counter oral contraceptive).

regulation to require coverage for over-the-counter contraceptives, but HHS withdrew the proposed rule following the election of Donald Trump, reportedly out of concern for President Trump's record on family planning.[371]

6. Gaps in Measurement and Assessment

"Maternal mortality is a general report card with regard to the quality of obstetric care in the United States."[372]

There is a dearth of disaggregated data on maternal health outcomes. Specifically, maternal mortality and morbidity information is frequently not disaggregated for Latinos and Asian Americans, and Pacific Islanders.[373] Additionally, most data on maternal mortality and morbidity reflect statistics of people who identify as women, leaving data incomplete on the systemic failure to improve maternal health of transgender and nonbinary birthing people.[374] This inhibits the ability of policymakers to fully understand the problem, and therefore inhibits the ability to craft appropriate solutions.

It is also important to collect information and assess ongoing programs and care models implemented to address the problem. Delivery system models frequently use quality measures to track performance and process,[375] but it is critical

---

[371] Noah Tong, *In Waning Days, Biden Withdraws Another Proposed Contraception Rule*, FIERCE HEALTHCARE (Jan. 14, 2025, at 17:00 PT), https://www.fiercehealthcare.com/regulatory/waning-days-biden-withdraws-another-proposed-contraception-rule (on file with the Lewis & Clark Law Review); *see* Eli Y. Adashi, Daniel P. O'Mahony & Glenn Cohen, *Paying for Over-the-Counter Contraception: The Opill Quandary*, 136 AM. J. MED. 200, 200 (2023) (describing the "aspirational goal" of the Biden Administration to increase access to over-the-counter contraceptives).

[372] Amnesty International, *supra* note 14, at 6.

[373] Janice Hata & Adam Burke, *A Systematic Review of Racial and Ethnic Disparities in Maternal Health Outcomes Among Asians/Pacific Islanders in the United States*, 5 ASIAN/PACIFIC ISLAND NURSING J. 139, 144 (2020); Diana N. Carvajal, Anna-Michelle Marie McSorley & Ruth Enid Zambrana, *Latine Reproductive Health and Data Inequities Across the Life Course: A Call to Action*, 114 AM. J. PUB. HEALTH, at S457, S457 (2024).

[374] Elizabeth Kukura, *Reconceiving Reproductive Health Systems: Caring for Trans, Nonbinary, and Gender-Expansive People During Pregnancy and Childbirth*, 50 J.L. MED. & ETHICS 471, 473, 478 (2022); *see also* Mari Greenfield & Zoe Darwin, *Trans and Non-Binary Pregnancy, Traumatic Birth, and Perinatal Mental Health: A Scoping Review*, 22 INT'L J. TRANSGENDER HEALTH 203, 203–04 (2021) (discussing how parental mental health continues to "reflect[] cis-heteronormativity," despite the increased recognition of trans and non-binary people becoming parents).

[375] *See, e.g.*, 42 U.S.C. § 1395jjj(b)(3) (mandating quality of care assessments and reporting); *see also* CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE SHARED SAVINGS PROGRAM QUALITY MEASURE BENCHMARKS FOR THE 2020/2021 PERFORMANCE YEARS 1 (2020), https://www.cms.gov/files/document/20202021-quality-benchmarks.pdf [https://perma.cc/6RCW-6523] (describing how delivery system models such as Accountable Care Organizations use quality-measure benchmarks across domains like patient experience,

that the measures relied upon focus on maternal health and consider different segments of the population. Even among the discussed CMMI models, the health outcomes measured focused on infant rather than maternal health, namely gestational age, preterm birth rate, and birth weight.[376] Maternal health was more of a focus within process measures, which measured the rate of C-sections and vaginal births following C-sections rates, as well as the rates of weekend deliveries (indicating lower incidence of planned inductions).[377] There are gaps in the measures developed. Most measures focus on facilities as opposed to individuals, which can mask individual provider performance and subsequently, the ability to hold providers accountable for subpar care provided.[378] Quality measures are not frequently stratified by race or ethnicity, insurance status, socioeconomic status, and language, which can make it difficult to identify if certain populations are receiving lower-quality care.[379] Notably, most quality measures do not focus on health equity.[380] This is because quality measures inherently consider the *average* quality of care that a given provider delivers to his or her patients—again, masking if care differs across race, ethnicity, gender identity, disability status, age, insurance type, and other characteristics.[381]

As a part of the Maternal Health Research Framework Initiative, CMS and the Agency for Healthcare Research and Quality should review existing quality measures adopted to consider how accurately these measures account for maternal health equity. Federally funded care delivery models should measure individual and facility performance on maternal and reproductive health. Additionally, CMS should build upon the Child Core Data Set requirements to require Medicaid programs to report on a robust set of maternal and perinatal quality measures.[382] While maternal and infant health are often linked, it is important that maternal health care models evaluate success or areas of improvement based on maternal, not just infant, health to truly understand the birthing person's health needs. There is also a need to ensure

safety, and preventative health to assess and improve care performance).

[376] HILL ET AL., *supra* note 171, at 136.

[377] *Id.* at 135–36.

[378] Peter B. Angood, Elizabeth Mitchell Armstrong, Diane Ashton, Helen Burstin, Maureen P. Corry et al., *Blueprint for Action: Steps Toward a High-Quality, High-Value Maternity Care System*, 20 WOMEN'S HEALTH ISSUES, at S18, S22 (2010).

[379] *See* RACHEL DEMEESTER & ROOPA MAHADEVAN, ADVANCING HEALTH EQUITY, USING DATA TO REDUCE DISPARITIES AND IMPROVE QUALITY 3 (2020), https://www.chcs.org/media/Using-Data-to-Reduce-Disparities-2021_Final.pdf [https://perma.cc/4WHR-7DDE].

[380] Denis Agniel, Irineo Cabreros, Cheryl L. Damberg, Marc N. Elliott & Rhianna Rogers, *A Formal Framework for Incorporating Equity into Heath Care Quality Measurement*, 42 HEALTH AFFS. 1383, 1383–84 (2023).

[381] *See* Alan R. Nelson, *Unequal Treatment: Report of the Institute of Medicine on Racial and Ethnic Disparities in Healthcare*, 76 ANNALS THORACIC SURGERY, at S1377, S1379–80 (2003).

[382] *See supra* note 224 and accompanying text.

that performance assessments, and subsequently, relied-upon measures, account for health disparities. For instance, California has demonstrated that successful implementation of pay-for-performance programs can positively improve maternal health outcomes but not benefit everyone equally. California reduced its maternal mortality rate by 65% over a ten-year period.[383] Key components of the state's quality improvement initiatives have been developing evidence-based quality improvement toolkits for leading causes of maternal deaths and complications, providing hospitals with the quality metrics, and collecting real-time data on the quality metrics.[384] Even still, stark disparities remain in California.[385]

These recommendations and opportunities are only illustrative. There are undoubtedly several other federal government decisions that perpetuate birth injustices and several opportunities to address long-standing systemic inequities. The focus here on executive action is also not to suggest that neither Congress or the courts have allowed birth injustices, nor that these bodies have no role in addressing them. To fully realize birth justice, Congress must enact sweeping structural and policy change, and the courts must recognize constitutionally protected birthing and reproductive rights. Even still, such reform is not alone sufficient to advance birth justice, and additional federal regulatory action will be necessary. Moreover, provider associations, such as the ACOG and the American Medical Association, also have a vital role in advancing birth justice. However, self-policing among the medical profession will always have an inherent conflict between patient and provider interests.[386] Additionally, leaving these policy decisions solely to the states would continue to allow inconsistency in access and outcomes across the country; and states in the South and Midwest, which have the worst maternal health outcomes in the country, are also the most resistant to expanding and improving government involvement in healthcare programs.[387] States and private industry have played a significant role in both perpetuating inequities and could enact meaningful policies to address inequities. Examining these actions are outside the scope of this Article.

---

[383] *What We Do*, CAL. MATERNAL QUALITY CARE COLLABORATIVE, https://www.cmqcc.org/who-we-are [https://perma.cc/T983-3FN6] (last visited Jan. 14, 2026).

[384] *Id.*

[385] *See* Ana B. Ibarra, *Most Maternal Deaths Can Be Prevented. Here's How California Aims to Cut Them in Half*, CALMATTERS (Sep. 17, 2024), https://calmatters.org/health/2024/09/maternal-deaths/ [https://perma.cc/KX2G-RGZ6].

[386] Troyen A. Brennan, *The Role of Regulation in Quality Improvement*, 76 MILBANK Q. 709, 713–15 (1998).

[387] *See Status of State Medicaid Expansion Decisions: Interactive Map (2024)*, KFF (Sep. 26, 2025), https://www.kff.org/affordable-care-act/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/ [https://perma.cc/SQ3V-QX39].

C. The Path Backward

Instead of moving toward birth justice, HHS has recently undertaken efforts that threaten to worsen maternal health disparities. First, and perhaps most significantly, the Trump Administration has prioritized rolling back administrative actions, programs, and federal funding that focus on equity.[388] As explained, maternal health equity, and subsequently, birth justice, cannot be achieved without considering the outcomes and causes for different populations, particularly racial inequities. Therefore, the anti-diversity, equity, and inclusion efforts can have life or death implications for pregnant and postpartum persons. Overall, administrative efforts to reduce the federal workforce are likely to have implications for federal programs and policy implementation without regard to the topic. In short, if there are no federal workers to implement or oversee a program, Congress' statutory directions or previously issued regulations will have no impact. Additionally, the budget reconciliation package, H.R. 1, previously known as the One Big Beautiful Bill, runs counter to the programs and policies contemplated in the named health laws discussed within this Article.[389]

As it relates to the specific areas discussed within this Section, the Trump Administration has reorganized significant portions of HHS, including the OCR.[390] It is unclear how this will impact the agency's oversight and enforcement efforts; however, the merger of OCR into another office could lead to deprioritizing civil rights protections. Further, eliminating any effort that considers diversity, equity and inclusion raises concerns that the agency will not seek to enforce prohibitions against racial discrimination.[391] For instance, the Cedars-Sinai voluntary settlement agreement includes commitments to address bias against Black women, and OCR is supposed to monitor the hospital's progress for three years.[392]

---

[388] *See, e.g.*, Exec. Order No. 14151, 90 Fed. Reg. 8339, 8339 (Jan. 20, 2025).

[389] *See* Pub. L. No. 119-21, 139 Stat. 72 (2025); *see also* Yasmeen Abutaleb & Maeve Reston, *States Face Massive New Costs Under Trump Budget Cuts*, WASH. POST (Sep. 8, 2025), https://www.washingtonpost.com/politics/2025/09/08/states-medicaid-snap-cuts-trump/ [https://perma.cc/5TLN-LDEE] ("States are scrambling to prepare for an unprecedented shift of costs and responsibilities under President Donald Trump's sweeping tax and spending plan, which will force them to make difficult decisions about cuts to state programs to offset the new financial burdens.").

[390] HHS has consolidated the Office of Civil Rights, Departmental Appeals Boards, and the Office of Medicare Hearings and Appeal under a New Assistant Secretary for Enforcement. *See Fact Sheet: HHS' Transformation to Make America Healthy Again*, U.S. DEP'T OF HEALTH & HUM. SERVS. (Apr. 2, 2025), https://www.hhs.gov/press-room/hhs-restructuring-doge-fact-sheet.html [https://perma.cc/KS9L-ZBKS].

[391] *See* Amani Echols, *Trump Administration's Executive Order Threatens a Historic Settlement that Could Improve Black Maternal Healthcare*, NAT'L P'SHIP FOR WOMEN & FAMS. (Feb. 18, 2025), https://nationalpartnership.org/trump-administrations-executive-order-threatens-a-historic-settlement-that-could-improve-black-maternal-healthcare/ [https://perma.cc/K6G5-SB8U].

[392] *Id.*; *see supra* notes 157–60 and accompanying text.

The Trump Administration has also undertaken administrative efforts that threaten to undermine investments in developing the perinatal workforce and improving access to critical care. HHS programs to expand the maternal health workforce are in limbo.[393] HRSA has significantly reduced its federal staff, including staff overseeing the Title V Maternal and Child Health Block Grant,[394] and staff maintaining the Maternal Mental Health Hotline, which had offered professional mental health counseling without cost, though the Administration has stated that the support line will remain operational.[395] President Trump's 2026 budget includes a proposed $1.73 billion reduction in funding from HRSA.[396] CMS also rescinded guidance issued from the Biden Administration that reminded and clarified for hospitals their responsibility to provide emergency care to people experiencing a pregnancy loss, ectopic pregnancy, or emergent hypertensive disorders, including in states that prohibit abortions.[397] While the statutory requirement to treat emergencies remains in effect, the Biden-era guidance—intended to ensure hospitals were clear on their existing obligations, even as states enacted abortion laws—has been rescinded.[398] Relatedly, HHS has actively undermined provider access, particularly to trusted family planning providers.[399] The Trump Administration has frozen previously-awarded grant funds to 16 Title X recipients under the guise of investigating diversity, equity, and inclusion efforts, threatening patients' access to

---

[393] *See* U.S. GOV'T ACCOUNTABILITY OFF., GAO-24-106271, MATERNAL HEALTH: HHS SHOULD IMPROVE ASSESSMENT OF EFFORTS TO ADDRESS WORSENING OUTCOMES 28–42 (2024).

[394] *See* Jessica Glenza, *Trump Administration Eviscerates Maternal and Child Health Programs*, THE GUARDIAN (Apr. 11, 2025, at 09:11 EDT), https://www.theguardian.com/us-news/2025/apr/05/maternal-child-health-cuts [https://perma.cc/5944-EZWL].

[395] Isabella Cueto, *HHS Cuts Leave Future of Mental Health, Substance Use Hotlines Uncertain*, STAT NEWS (Apr. 3, 2025), https://www.statnews.com/2025/04/03/national-quit-line-mental-health-hotline-hhs-cuts/ [https://perma.cc/3PQ6-LMWW].

[396] U.S. DEP'T OF HEALTH & HUM. SERVS., FISCAL YEAR 2026 BUDGET IN BRIEF 1–4 (2025), https://www.hhs.gov/sites/default/files/fy-2026-budget-in-brief.pdf [https://perma.cc/WU83-SBDF] (summarizing the budget changes); *see also* Emma Beavins, *President Trump Outlines Health Agency Cuts in Annual FY26 Budget Proposal*, FIERCE HEALTHCARE (May 2, 2025, at 11:41 PT), https://www.fiercehealthcare.com/regulatory/president-trump-outlines-health-agency-cuts-annual-fy26-budget-proposal [https://perma.cc/5GWQ-XNQM] (calculating the proposed budget reduction).

[397] Rescinded Memorandum from Dirs., Quality, Safety & Oversight Grp. (QSOG) & Surv. & Operations Grp. (SOG), Ctrs. for Medicare & Medicaid Servs. to State Surv. Agency Dirs. 3–6 (May 29, 2025), https://www.cms.gov/files/document/qso-22-22-hospitals-rescinded-05292024.pdf [https://perma.cc/2HGD-9F8U].

[398] *Id.*

[399] Chantelle Lee, *Title X Freeze Widely Threatens Health Care Access*, TIME (Apr. 11, 2025, at 06:09 PT), https://time.com/7276543/title-x-funding-freeze-threatens-states/ [https://perma.cc/E4FM-FZUC]

the family planning and preventive services the program affords.[400] The Administration has also fired and rehired the federal staff administering the program, and it appears the Administration has stopped awarding new Title X grants without notice or explanation.[401] Further, it is anticipated that the Trump Administration will promulgate a rule, as it did during its first term, imposing stringent requirements upon Title X recipients that provide abortion.[402] This regulation resulted in a reduction of nearly 50% of the network in 2019.[403]

There have also been administrative actions that undermine coverage for maternity services. Consistent with President Trump's rescission of Executive Order 14009, which President Biden signed in 2021, committing to strengthening the ACA and Medicaid,[404] HHS has issued a regulation shortening the annual enrollment window for ACA marketplace plans, imposing additional income verification requirements for financial assistance to purchase private plans, and inhibiting consumers' ability to be auto enrolled into no-cost plans.[405] These

---

[400] *See* Praveena Somasundaram, *Trump Administration Freezes Tens of Millions in Family Planning Funding*, WASH. POST (Apr. 1, 2025), https://www.washingtonpost.com/nation/2025/03/31/planned-parenthood-title-x-funding/ [https://perma.cc/YG9S-NJH2]; *see also* Brittni Frederiksen, Ivette Gomez & Alina Salganicoff, *Title X Grantees and Clinics Affected by the Trump Administration's Funding Freeze*, KFF (Apr. 15, 2025), https://www.kff.org/womens-health-policy/issue-brief/title-x-grantees-and-clinics-affected-by-the-trump-administrations-funding-freeze/ [https://perma.cc/8C3N-EGCB] (providing a list of "Title X Grantees and Clinics Affected by the Trump Administration's Funding Freeze").

[401] Céline Gounder, *The Quiet Collapse of America's Reproductive Health Safety Net*, KFF HEALTH NEWS (Oct. 30, 2025), https://kffhealthnews.org/news/article/title-x-family-planning-hhs-opa-trump-cuts-reproductive-health-maine/ [https://perma.cc/7UPP-B3VV]; Alice Miranda Ollstein, *'Damaging and Punishing': Birth Control Clinics Serving Millions Face Federal Funding Cliff*, POLITICO (Mar. 11, 2026, at 09:00 EDT), https://www.politico.com/news/2026/03/11/damaging-and-punishing-birth-control-clinics-serving-millions-face-federal-funding-cliff-00821804 [https://perma.cc/RS7X-BMSJ].

[402] Frederiksen et al., *supra* note 400; *see, e.g.*, Compliance With Statutory Program Integrity Requirements, 84 Fed. Reg. 7714, 7714 (Mar. 4, 2019) (summarizing regulation amendments to ensure Title X funding was "not used in programs where abortion is a method of family planning"), *superseded by,* Ensuring Access to Equitable, Affordable Client-Centered, Quality Family Planning Services, 86 Fed. Reg. 56144, 56144 (Oct. 7, 2021) (codified at 42 C.F.R. pt. 59) (revising regulations to remove restrictions on abortion counseling or referrals and "eliminating requirements for strict physical and financial separation between abortion-related activities and Title X project activities").

[403] Ruth Dawson, *Trumps Administration's Domestic Gag Rule has Slashed the Title X Network's Capacity by Half*, GUTTMACHER INST. (Apr. 15, 2021), https://www.guttmacher.org/article/2020/02/trump-administrations-domestic-gag-rule-has-slashed-title-x-networks-capacity-half [https://perma.cc/Q3AX-MFD9].

[404] Exec. Order No. 14148, 90 Fed. Reg. 8237, 8238 (Jan. 28, 2025).

[405] 45 C.F.R. § 155.410(e)(5) (2026) (shortening the enrollment window to no more than nine weeks); *id.* § 155.320(c)(5) (requiring IRS income verification to determine eligibility); *id.* § 155.410(f) (inhibiting auto enrollment).

administrative actions will no doubt impact maternal health care access given the millions of people who gained access to maternal and newborn care following the implementation of the ACA.[406] The Secretary of HHS has also interfered with the U.S. Preventive Services Task Force, including abruptly canceling meetings,[407] and there are reports that the Secretary is planning to replace the entire expert body.[408] This has raised concerns about political influence in a medical and scientific body intended to operate independently.[409] The CDC also updated its immunization guidance to remove the recommendations that healthy pregnant women receive the COVID-19 vaccine.[410] This is particularly concerning given the change was reportedly implemented without the consultation of the expert body tasked with recommending immunizations, and it comes amidst existing hesitancy among pregnant women to be inoculated.[411] It is also anticipated that HHS will extend, as it did during President Trump's first term, the availability of short-term plans and other non-ACA-compliant plans, which do not have to cover the EHBs or the preventive services requirement, and may engage in gender rating.[412] Even without additional rulemaking, the Departments of Labor, Treasury, and HHS has

---

[406] ALLSBROOK & AHMED, *supra* note 205, at 1.

[407] *See, e.g.*, CHELSEA CIRRUZZO, *Kennedy Abruptly Cancels Preventive Care Committee Meeting*, STAT NEWS (July 9, 2025), https://www.statnews.com/2025/07/09/uspstf-rfk-jr-meeting-canceled-preventive-care/ [https://perma.cc/VYE5-JTLL] ("Health [S]ecretary Robert F. Kennedy Jr. has abruptly canceled a meeting of a key expert panel that evaluates the nation's preventative care recommendations.").

[408] Adriel Bettelheim, *RFK Jr. Reportedly Plans to Fire Preventive Care Task Force*, AXIOS (July 28, 2025), https://www.axios.com/2025/07/28/kennedy-preventive-service-task-force-firing (on file with the Lewis & Clark Law Review); Nina Agrawal, Maggie Astor & Dani Blum, *Kennedy Weakens U.S. Preventive Services Task Force*, N.Y. TIMES (Jan. 9, 2026), https://www.nytimes.com/2026/01/09/well/rfk-jr-uspstf-task-force.html [https://perma.cc/D7PT-VKBN].

[409] *See*, *e.g.*, Arthur Allen, *Changes at NIH Give Political Appointees Greater Power to Fund or Block Research*, KFF: HEALTH NEWS (Sep. 3, 2025), https://kffhealthnews.org/news/article/nih-grants-trump-political-appointees-agenda-alignment-peer-review/ [https://perma.cc/4T5W-8TME].

[410] Jason L. Schwartz, *Revised Recommendations for COVID-19 Vaccines—U.S. Vaccination Policy Under Threat*, 393 NEJM 417, 417 (2025).

[411] Despite the evidence-based safety and effectiveness of the COVID-19 vaccine for pregnant women and infants, the rates for vaccinations among pregnant women has significantly lagged behind the rest of the population. Petros Galanis, Irene Vraka, Olga Siskou, Olympia Konstantakopoulou, Aglaia Katsiroumpa & Daphne Kaitelidou, *Uptake of COVID-19 Vaccines among Pregnant Women: A Systematic Review and Meta-Analysis*, VACCINES, May 12, 2022, at 1, 1.

[412] *See* Michelle Long, Emma Lee & Sammy Cervantes, *Examining Short-Term Limited-Duration Health Plans on the Eve of ACA Marketplace Open Enrollment*, KFF (Oct. 15, 2025), https://www.kff.org/patient-consumer-protections/examining-short-term-limited-duration-health-plans-on-the-eve-of-aca-marketplace-open-enrollment/ [https://perma.cc/D68L-WJZK].

announced that it will not enforce existing regulatory limitations on short-term limited duration insurance.[413] Furthermore, the budget reconciliation law has created new statutory obligations for HHS to implement and ensure enforcement measures for Medicaid and private plans purchased on the ACA marketplaces, and this law is projected to eliminate nearly three-fourths of the coverage gains made under the ACA.[414] HHS will also be tasked with ensuring that federal Medicaid funds are withheld from certain family planning providers, namely Planned Parenthood and Maine Family Planning health centers, for one year, a measure that Planned Parenthood predicts will close one-third of its health centers.[415]

Despite the need for additional research on maternal health, the NIH has canceled research grants previously awarded to academic institutions and other organizations to study maternal health inequities, apparently as a part of the Administration's efforts to purge all diversity, equity, and inclusion efforts within and outside of the government.[416] Simultaneously, the federal government's ability to collect its own maternal health data has also been diminished. On January 31, 2025, HHS ceased collecting data through PRAMS.[417] Even more, the federal

[413] *Statement of U.S. Departments of Labor, Health and Human Services, and the Treasury Regarding Short-Term, Limited Duration Insurance*, DEP'T OF LAB. (Aug. 7, 2025), https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/short-term-limited-duration-insurance/stldi-statement-08-07-2025 [https://perma.cc/JGY5-6MK4].

[414] Pub. L. No. 119-21, § 71303, 139 Stat. 72, 323 (2025); *see* Jennifer Lubell, *4 "Big, Beautiful Bill" Changes that Will Reshape Care in 2026*, AM. MED. ASS'N (Dec. 10, 2025), https://www.ama-assn.org/health-care-advocacy/federal-advocacy/4-big-beautiful-bill-changes-will-reshape-care-2026 [https://perma.cc/R8WT-KFGZ].

[415] Press Release, Planned Parenthood, BREAKING: 200 Health Centers at Risk of Closure if Republicans "Defund" Planned Parenthood (May 21, 2025), https://www.plannedparenthoodaction.org/pressroom/breaking-200-health-centers-at-risk-of-closure-if-republicans-defund-planned-parenthood [https://perma.cc/TTR3-NNTN]; *Maine Family Planning Clinics Remain Open and Committed to Serving You*, ME. FAM. PLAN. (Oct. 3, 2025), https://mainefamilyplanning.org/health-care/maine-family-planning-clinics-remain-open-and-committed-to-serving-you/ [https://perma.cc/U5UG-AAAL].

[416] Jessie Hellmann, *Trump Cancels NIH Grants on Equity Research*, ROLL CALL (Mar. 24, 2025, at 18:18 PT), https://rollcall.com/2025/03/24/trump-cancels-nih-grants-on-equity-research/ [https://perma.cc/6DC6-PDXC]; *see generally* TRACKING ACCOUNTABILITY IN GOV'T GRANTS SYS., HHS GRANTS TERMINATED (2025) https://taggs.hhs.gov/Content/Data/HHS_Grants_Terminated.pdf [https://perma.cc/2DZX-9EUR] (listing recently terminated grants).

[417] John Marshall, *CDC Shutters PRAMS Program on Maternal and Infant Health*, TALKING POINTS MEMO (Feb. 22, 2025, at 16:18 PT), https://talkingpointsmemo.com/edblog/cdc-shutters-prams-program-on-maternal-and-infant-health [https://perma.cc/E5HA-9KE2]; *see supra* note 223 and accompanying text.

grants the CDC awards to states to implement PRAMS research are scheduled to end in April 2026, and the uncertain future has already led some states to cease participation.[418] Similarly, staff from the CDC Division for Reproductive Health, which maintain PRAMS, as well as study maternal, reproductive and infant health broadly, have reportedly been fired.[419]

There is also concern that the Trump Administration's executive order, declaring the federal government's official position refusing to recognize the existence of transgender, nonbinary, and intersex people, will further impede the ability to understand maternal health outcomes for people who do not identify as women.[420] For instance, the CDC were directed to remove from documents and websites, including publications submitted to academic journals, "pregnant person" or "pregnant people," as well as other gender inclusive language, and similarly, the NIH terminated research grants related to gender.[421] Similarly, the Administration scaled back public education and information available on maternal health. Illustratively, a content analysis of womenshealth.gov found that "[a]ll of the material removed from the website was maternal health and reproductive health care information."[422]

This Section accounts for actions toward the beginning of the Trump Administration's second term, namely within the first year, but there will no doubt

---

[418] Jamie Daw, Heidi L. Allen, Jess Maksut & Laurie C. Zephyrin, *What is the Pregnancy Risk Assessment Monitoring System, and Why is it at Risk?*, COMMONWEALTH FUND (Jan. 20, 2026), https://www.commonwealthfund.org/publications/explainer/2026/jan/what-is-prams-and-why-is-it-at-risk [https://perma.cc/29HJ-ZHEJ].

[419] Anil Oza, *Gold-Standard Maternal Mortality Database in Limbo as CDC Staff Placed on Leave*, STAT NEWS (Apr. 1, 2025), https://www.statnews.com/2025/04/01/prams-maternal-mortality-cdc-layoffs/ [https://perma.cc/B7YP-JLTW]; Jessica Glenza, *Trump Administration Eviscerates Maternal and Child Health Programs*, THE GUARDIAN (Apr. 11, 2025, at 09:11 EDT), https://www.theguardian.com/us-news/2025/apr/05/maternal-child-health-cuts [https://perma.cc/5944-EZWL].

[420] Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government, Exec. Order No. 14168, 90 Fed. Reg. 8615, 8616 (Jan. 20, 2025) (declaring that "[i]t is the policy of the United States to recognize two sexes, male and female," and "[a]gencies shall take all necessary steps, as permitted by law, to end the Federal funding of gender ideology"); *see* ELANA REDFIELD & ISHANI CHOKSHI, UCLA SCH. OF L. WILLIAMS INST., IMPACT OF THE EXECUTIVE ORDER REDEFINING SEX ON TRANSGENDER, NONBINARY, AND INTERSEX PEOPLE 9 (2025), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Sex-Definition-EO-Jan-2025.pdf [https://perma.cc/CBB2-PDJ3] (explaining that the executive order will make it "nearly impossible for researchers to make observations about transgender experiences using those [federal government] data").

[421] Patricia A. Homan & Susan E. Short, *Rewriting Women's Health: A Content Analysis of the Trump Administration's Revisions to Womenshealth.gov*, 51 LANCET REG'L HEALTH—AMS., Nov. 2025, at 1, 1–2.

[422] *Id.* at 2; *see* U.S. DEP'T OF HEALTH & HUM. SERVS., OFF. ON WOMEN'S HEALTH, https://womenshealth.gov/ [https://perma.cc/9MMW-AHTX].

be other policies impacting maternal health. For this reason, this account is not comprehensive, but it illustrates the significant impact that often-overlooked regulations and administrative actions have in the pursuit of social justice, and more importantly people's lives.

III. OVERCOMING BARRIERS TO AN ADMINISTRATIVE RESPONSE

Administrative actions have been an underutilized tool, in part, because conservatives have stoked fears regarding unelected bureaucrats making laws without oversight, while liberals have responded with paralysis—afraid to feed into those concerns.[423] This problem began long before the recent undertakings of President Trump. Section III.A explores the interplay between Congress and federal agencies, and responds to concerns about agencies imposing Congress' legislative authority and inherent limitations that prevent federal agencies from enacting regulations and guidance or undertaking enforcement actions without limits. The Section discusses the limitations to both acknowledge the inherent barriers to advancing birth justice through administrative actions and to respond to concerns about the administrative state.

The Supreme Court's recent handling of regulations and other agency actions may warrant a seismic shift in how agencies, across political administrations, have operated for decades. Specifically, the Court in *Loper Bright Enterprises* decided in 2024 to overturn nearly 40 years of precedent when it held that courts are no longer required to defer to agency interpretations if a statute is ambiguous.[424] The Court has also begun to invoke the major questions doctrine, under which the Court has stated that it will presume that Congress did not intend for a federal agency to undertake politically and economically significant action absent clear statutory direction to the contrary. Of course, the cases discussed are recent decisions and questions remain. This Section seeks to outline a path forward for regulators and advocates concerned with maternal health. Section III.B provides an overview of recent court decisions and outlines broad guiding principles that administrative agencies will need to consider if seeking to advance birth justice through regulations, guidance, and enforcement. Overall, this Section seeks to answer if undertaking the policy recommendations outlined with this Article is legally and practically possible.

A. Politics and Congress

An underlying concern of administrative actions is that these agencies obstruct separation of powers principles, particularly undermining Congress' legislative

[423] *See* JON D. MICHAELS, CONSTITUTIONAL COUP: PRIVATIZATION'S THREAT TO THE AMERICAN REPUBLIC 90–91, 112–13, 116–17, 219 (2017).

[424] Loper Bright Enters. v. Raimondo, 144 S. Ct. 2244, 2273 (2024).

authority and the Court's authority to interpret the law.[425] But, Congress has multiple avenues to direct and influence administrative actions, and as discussed below, *Loper Bright Enterprises* is demanding an even higher standard before an agency can act. First, Congress can—and should—provide direction to administrative agencies by clearly stating its intent for a law and by providing specific implementation directions.[426] Congressional intent has always served as a check on administrative agencies, and health care laws, generally, must promote the nation's health and well-being.[427] For example, before the recent reconciliation bill, lower courts concluded multiple times that conditioning Medicaid eligibility upon community engagement or work requirements was not "'likely to assist in promoting the objectives'" of the Medicaid program as is required by the Medicaid Act, a core objective of which is to cover health care services for people with low incomes.[428]

Congress has also provided direction to administrative agencies regarding policy making. For instance, the congressionally enacted Administrative Procedures

---

[425] Cynthia R. Farina, *Statutory Interpretation and the Balance of Power in the Administrative State*, 89 COLUM. L. REV. 452, 456, 460–63 (1989) (arguing that *Chevron* deference reallocates power away from the legislative branch's duty to enact laws and the judiciary's role to interpret the law); Christopher J. Walker, *Attacking* Chevron *and* Auer *Deference: A Literature Review*, 16 GEO. J.L. & PUB. POL'Y 103, 110–11 (2018) (summarizing criticisms of *Chevron* deference). *But see* Cass R. Sunstein, *Law and Administration After* Chevron, 90 COLUM. L. REV. 2071, 2077–78, 2116, 2119 (1990) (arguing that *Chevron* can be read as consistent with separation of power principles); Kent Barnett, *How* Chevron *Deference Fits into Article III*, 89 GEO. WASH. L. REV. 1143, 1163–65, 1168–71 (2021) (explaining how *Chevron* fits into jurisprudence on Article III).

[426] *See* U.S. CONST. art. I, § 1 (granting "[a]ll legislative powers" to Congress, which permits Congress to provide direction to implementing agencies and entities).

[427] *See* Farina, *supra* note 425, at 485.

[428] *See* Gresham v. Azar, 363 F. Supp. 3d 165, 173, 178–82 (D.D.C. 2019) (quoting 42 U.S.C. § 1315(a)) (concluding that the Arkansas § 1115 waiver must be struck down to comply with the Administrative Procedures Act requirement to set aside agency actions which are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law" (quoting 5 U.S.C. § 706(2))). State attempts to attach community engagement or work requirements as a condition to Medicaid eligibility through the Medicaid pilot project provision (known as § 1115 waivers) have been struck down in Kentucky, Stewart v. Azar, 313 F. Supp. 3d 237, 246, 274 (D.D.C. 2018); New Hampshire, Philbrick v. Azar, 397 F. Supp. 3d 11, 17, 32 (D.D.C. 2019); and Arkansas, *Gresham*, 363 F. Supp. 3d at 182. The Supreme Court previously agreed to hear a challenge to the community engagement waivers, but this case was removed from the Supreme Court's oral argument calendar following a change of the presidential administrations from the Trump Administration, who approved these waivers, to the Biden Administration, who did not support these waivers. Lawrence Hurley, *U.S. Supreme Court Scraps Arguments in Medicaid Work Case*, REUTERS (Mar. 11, 2021, at 08:39 PST), https://www.reuters.com/article/us-usa-court-medicaid/u-s-supreme-court-scraps-arguments-in-medicaid-work-case-idUSKBN2B32D8/ (on file with the Lewis & Clark Law Review). H.R. 1, discussed within, permits states to impose work requirement and makes this issue moot. *See* Pub. L. No. 119-21, § 71119, 139 Stat. 72, 81 (2025).

Act (APA) governs the rulemaking process, including the requirement to justify policy decisions for implementing regulations and guidance across the federal government.[429] The APA also requires agencies to engage in reasoned decision making.[430] For example, federal district courts, at least five times, blocked the first Trump Administration's attempt to terminate grants awarded under the Teen Pregnancy Prevention Program without adequate explanation.[431] Similarly, a court has struck down administrative rules after questioning the validity of the agency's rule justification.[432] The APA also specifically demands that agencies consider the public's comments.[433] A federal district court in *City of Columbus v. Cochran*, found that HHS' decision, under the Trump Administration, to rely on states and accrediting bodies to review plan networks was arbitrary and capricious because the agency had not adequately responded to public comments raising important concerns.[434] Even more, Congress is able to enact legislation to alter the existing deference framework that courts apply.[435] In fact, *Loper Bright Enterprises*, in part, relies upon APA language explaining that the judiciary determines what the law is, and the Court similarly notes Congress has required courts to offer deference to "agency policymaking and factfinding."[436]

Additionally, Congress also maintains an oversight role over administrative actions. For instance, Congress has multiple oversight committees tasked with monitoring agency actions.[437] Congress can, and frequently does, write into legislation a requirement to submit a report to Congress regarding the implementation of a law.[438] The Congressional Review Act is another law which

---

429 Administrative Procedure Act, 5 U.S.C. §§ 551–59; Jerry L. Mashaw, *Prodelegation: Why Administrators Should Make Political Decisions*, 1 J.L., ECON. & ORG. 81, 91, 96, 97 (1985).

430 5 U.S.C. § 706(2).

431 *See* Jennifer Hansler, *HHS Loses Another Court Battle over Teen Pregnancy Prevention Grant Funding*, CNN (June 4, 2018, at 15:17 EDT), https://www.cnn.com/2018/06/02/politics/hhs-teen-pregnancy-program-dc-district-court/index.html [https://perma.cc/HPN8-2XSG].

432 The U.S. District Court for the Southern District of New York struck down the Trump Administration's justification for allowing health care entities and individuals broad discretion to refuse care for religious and moral beliefs. The court explicitly noted that some of the Administration's arguments "cannot be taken seriously." New York v. U.S. Dep't of Health & Hum. Servs., 414 F. Supp. 3d 475, 506–07, 512–513 (S.D.N.Y. 2019).

433 5 U.S.C. § 553.

434 City of Columbus v. Cochran, 523 F. Supp. 3d 731, 751 (D. Md. 2021).

435 JOSH CHAFETZ, CONGRESS'S CONSTITUTION: LEGISLATIVE AUTHORITY AND THE SEPARATION OF POWERS 64–65 (2017).

436 Loper Bright Enters. v. Raimondo, 144 S. Ct. 2244, 2261 (2024) (citing 5 U.S.C. § 706(2)(A), (E)).

437 *See, e.g.*, *About*, COMM. ON OVERSIGHT & ACCOUNTABILITY, https://oversight.house.gov/about [https://perma.cc/XF5G-4DKP] (last visited Jan. 19, 2026).

438 WILLIAM T. EGAR, CONG. RSCH. SERV., R46357, CONGRESSIONALLY MANDATED

governs most agency regulations and guidance, and provides Congress with a look back period whereby Congress is able to pass a resolution to rescind an agency regulation or guidance that has been finalized within the 60 legislative days prior.[439] Lastly, and perhaps, most impactfully, Congress maintains its constitutionally granted power of the purse: Agencies are at the whim of Congress authorizing and appropriating funds to implement policies, even when an administration has authority to implement a policy.[440]

Critics of expansive administrative actions also claim that "but for" agencies interference, Congress would return to a purer form of legislating.[441] For instance, the notice and comment rulemaking process has been cited as an opportunity for organizations and lobbyists to influence bureaucrats.[442] Yet, influencing any form of law and policy making is a reality no matter the federal branch promulgating the policy.[443] Without agencies to address complex questions, even the most well-meaning congressmember, and more precisely, congressional staff, might come to rely upon outside influences even more, given advocacy organizations and lobbyists often have the time and structure to develop expertise in an issue area.[444]

To be clear, regulations, guidance, and other administrative actions are not a panacea to the maternal health crisis that has resulted from multiple systemic failures influencing individuals health throughout their lifetime, long before becoming pregnant. Specifically, administrative actions do have multiple inherent limitations and barriers. Notably, as Section II illustrates, these policies may not have the longevity of a statute. Federal agencies can change a policy every four or eight years—which is not enough time to address the engrained health care disparities and

---

REPORTS: OVERVIEW AND CONSIDERATIONS FOR CONGRESS 1–6 (2020).

[439] Congressional Review Act, 5 U.S.C. §§ 801–02.

[440] U.S. CONST. art. I, § 9 (granting Congress the power of the purse). Specifically, the Constitution states that Congress must enact a law to appropriate funds from the U.S. Treasury. *Id. But see* Rescissions Act of 2025, Pub. L. No 119-28, 139 Stat. 467, 467–69 (2025) (rescinding funds Congress previously appropriated); DEVIN O'CONNOR, SAM BERGER & JACOB LEIBENLUFT, CTRS. ON BUDGET & POL'Y PRIORITIES, TRUMP RECISSION PROPOSAL BUILDS ON ILLEGAL IMPOUNDMENTS, WOULD UNDERMINE FUTURE FUNDING DEALS 5–7 (2025) (characterizing Congress' recent passage of a recissions package as Congress relinquishing its appropriation authority at the request of the White House).

[441] Farina, *supra* note 425, at 480; Walker, *supra* note 425, at 117; Michael S. Greve & Ashley C. Parrish, *Administrative Law Without Congress*, 22 GEO. MASON L. REV., 501, 502–03 (2015).

[442] Elizabeth Warren, *Corporate Capture of the Rulemaking Process*, REGUL. REV. (June 14, 2016), https://www.theregreview.org/2016/06/14/warren-corporate-capture-of-the-rulemaking-process/ [https://perma.cc/KHR4-777N].

[443] *See* Mashaw, *supra* note 429, at 96–97.

[444] A congressional select committee explained that an increased demand for information and expertise without internal government support has led to staffers and members needing to rely upon outside organizations. H.R. REP. NO. 117-646, at 125–30 (2022).

systemic racism that have been born and fed since the founding of this country.

B. The Courts

The Supreme Court is affording federal agencies less deference, which will limit agencies' ability to enact meaningful policies, and will impact both the substance and process that can be used to propagate regulations and controlling guidance. Even still, the extent of the shift remains to be seen.[445] Here, I seek to examine recent cases to discern if and where a path remains for regulators and advocates to secure birth justice through federal agencies.[446] The focus here is not to debate the merits of the recent cases but instead to discern how regulators and advocates seeking to advance administrative actions can be productive under the current Court's jurisprudence. The extent to which *Loper Bright Enterprises* will impact agency regulations will depend not only on how courts interpret the Supreme Court decision, but also—and perhaps, even more—how agency general counsel and regulators interpret and respond to the decision.[447]

1. Chevron *Deference Doctrine*

In 1984, the Supreme Court in *Chevron U.S.A. v. Natural Resources Defense Council, Inc.* created a two-part framework to determine whether a federal agency exceeded its statutory authority in enacting a regulation or rule.[448] First, a court would look to determine whether a statute was ambiguous, and if a statute was ambiguous, a court would assess whether an agency's interpretation was reasonable.[449] Thus, a key premise of the *Chevron* doctrine has been that an

---

[445] *See generally* Cary Coglianese & Daniel E. Walters, *The Great Unsettling: Administrative Governance After* Loper Bright, 77 ADMIN. L. REV. 1 (2025) (breaking down the ambiguities and possible ramifications of Loper Bright Enters. v. Raimondo, 144 S. Ct. 2244 (2024)).

[446] The cases discussed here are not the only recent Supreme Court decisions with the potential to impact the administrative state. The focus here is upon cases I believe have the most impact on the policy recommendations offered here, given these cases primarily consider the substance of the regulatory action. Even still, in *SEC v. Jarkesy*, the Supreme Court limited an agency from imposing civil penalties on a defendant without affording the defendant a jury trial under the Seventh Amendment, which could potentially impact agencies' enforcement authority beyond the SEC. 144 S. Ct. 2117, 2130 (2024). Similarly, in *Corner Post, Inc. v. Board of Governors of the Federal Reserve System*, the Court ruled that the statute of limitations for a claim filed under the APA does not begin until the alleged harm occurs, not when the regulation is issued. 144 S. Ct. 2440, 2447–48 (2024). This decision could potentially open federal agencies to an increased amount of litigation because it extends the timeframe and subsequently, the impacted parties able to challenge a decision. *Id.*

[447] *See* Coglianese & Walters, *supra* note 445, at 31 ("A new equilibrium could be established whereby agency win-rates post-*Loper Bright* look the same as under *Chevron*, but this could be an artifact of agencies' more cautious adaptation to their new legal requirement.").

[448] Chevron U.S.A. v. Nat. Res. Def. Council, Inc., 467 U.S. 837, 842–43 (1984).

[449] *Id.* at 843; *see Loper Bright*, 144 S. Ct. at 2254 (2024) (explaining that the standard of an

ambiguity within the statutory text should result in deference to the relevant federal agency, absent statutory authority to the contrary.[450] The Court in *Loper Bright Enterprises* reasoned that the *Chevron* test violates the APA because it is the court's role to say what the law is, so the judiciary should interpret statutes and decide if the agency interpretation is consistent with the law.[451] The Court writes, "Courts must exercise their independent judgment in deciding whether an agency has acted within its statutory authority, as the APA requires."[452] Chief Justice John Roberts, writing for the majority, concluded the *Chevron* doctrine had been a distraction from considering whether a statute authorized the agency action.[453]

The Court in *Loper Bright Enterprises* reaffirms Congress' ability to delegate to federal agencies the authority to implement policy and subsequently, the Court upholds agencies' ability to exercise discretion over policy decisions. The Court explicitly notes that a "statute's meaning may well be that the agency is authorized to exercise a degree of discretion."[454] Specifically, the Court states Congress may direct an agency to define a "particular statutory term" or "'fill up the details'" of a statutory scheme.[455] The Court also acknowledges in *Loper Bright Enterprises* that courts should "stay out of discretionary policymaking," and stick to reviewing the "outer statutory boundaries of [congressional] delegations."[456] The Court also notes that Congress often "'leaves agencies with flexibility.'"[457] The federal courts have long upheld Congress' ability to delegate to agencies as long as Congress provides directions to the federal agencies or an "'intelligible principle'" for an agency to pursue.[458]

Cases decided before *Chevron* may be instructive as to the approach the Court will now follow when reviewing agency actions. For questions of legal

---

agency's interpretation under *Chevron* is "if it 'is based on a permissible construction of the statute'" (quoting *Chevron*, 467 U.S. at 843)).

[450] *See Chevron*, 467 U.S. at 843–45; *see also* United States v. Mead Corp., 533 U.S. 218, 221 (2001) (holding that the highly deferential *Chevron* standard should be applied where Congress appears to delegate authority to an agency to generally make rules that carry the force of law).

[451] *Loper Bright*, 144 S. Ct. at 2265–66.

[452] *Id.* at 2273.

[453] *Id.* at 2269–70.

[454] *Id.* at 2263.

[455] *Id.* (quoting Wayman v. Southard, 10 Wheat. 1, 43 (1825)).

[456] *Id.* at 2268.

[457] *Id.* at 2263 (quoting Michigan v. EPA, 576 U.S. 743, 752 (2015)).

[458] Gundy v. United States, 139 S. Ct. 2116, 2119 (2019) (quoting Mistretta v. United States, 488 U.S. 361, 372 (1988)) ("[T]he Court has held, time and time again, that a statutory delegation is constitutional as long as Congress 'lays down by legislative act an intelligible principle to which the person or body authorized to [exercise the delegated authority] is directed to conform.'" (quoting *Mistretta*, 488 U.S. at 372)).

interpretation, the Court indicated that *Skidmore v. Swift & Co.* will guide judicial review of agency interpretations.[459] Under *Skidmore* deference, courts could still consider an agency's interpretation, particularly if the interpretation was issued contemporaneously with the statute.[460] *Skidmore* provides that courts should closely examine an agency's rationale for its interpretation and afford deference accordingly.[461] In other words, *Skidmore* permitted courts to consider an agency's interpretation, but the courts were not bound to an agency's interpretation. The extent that an agency's interpretation was considered "depend[ed] upon the thoroughness evident in [the agency's] consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade, if lacking power to control."[462]

In short, the overturning of *Chevron* does not preclude federal agencies from having a meaningful role in advancing substantive health policies. *Chevron* has been most relevant when Congress has failed to provide implementing directions or when those directions are ambiguous.[463] Additionally, even without the courts affording controlling deference to agencies, federal agencies still maintain their role in implementing laws. Notably, the Supreme Court has not applied *Chevron* deference since 2016, and this has not resulted in the death knell for all administrative actions.[464] Federal agencies also ceased relying upon deference at that time.[465]

Moving forward, regulators will need to look for clear authorities and clear instructions to act. In other words, an agency should look for statutes that provide clear direction to the agency to enact policies, as opposed to justifying its policy decisions as a reasonable interpretation. Courts have, whether applying *Chevron* or not, employed traditional means of statutory interpretation to determine whether an agency has acted consistently with a statute's text and Congress' intent.[466] Traditional rules of statutory interpretation include reviewing the statutory language, legislative history, and congressional findings.[467] Therefore, the Court will

---

[459] *See Loper Bright*, 144 S. Ct. at 2259 (citing Skidmore v. Swift & Co., 323 U.S. 134 (1944)).

[460] *Id.* at 2262 (citing *Skidmore*, 323 U.S. at 140).

[461] *Skidmore*, 323 U.S. at 140 ("[T]he rulings, interpretations and opinions of [agencies], while not controlling upon the courts by reason of their authority, do constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance.").

[462] *Id.*

[463] *See* Chevron U.S.A. v. Nat. Res. Def. Council, Inc., 467 U.S. 837, 842–44 (1984); Sunstein, *supra* note 415, at 2075.

[464] *Loper Bright*, 144 S. Ct. at 2269; *see* Buffington v. McDonough, 143 S. Ct. 14, 21 (2022).

[465] ASCHER ET AL., *supra* note 34, at 1.

[466] *Buffington*, 143 S. Ct. at 17–18.

[467] *See* James Kunhardt & Anne Joseph O'Connell, *Judicial Deference and the Future of*

still look to employ these tools to determine congressional intent and whether the statute is "clear." It also appears that the Court is more likely to uphold a regulation if it is consistent with previous agency interpretations.[468]

The policy recommendations offered in this Article can comply with the *Loper Bright Enterprises* standard. Each of the policy recommendations names the specific statutory authority to act. Namely, the policy recommendations could be enacted pursuant to the ACA, Medicaid, and HRSA governing statutes. Agencies typically have broader discretion under their spending authority, including to tie payment to conditions, as permitted under both the ACA and Medicaid.[469] Relatedly, these statutes allow for the development of the innovative delivery care models.[470] The HRSA statute is also clear in permitting the agency to expand the perinatal workforce.[471] The ACA appears to not only permit HHS to promulgate regulations governing the EHBs or network adequacy, but the statute requires it.[472] While the ACA and Medicaid statutes are not specific to maternal health, Congress intended them to improve the nation's health, which necessarily includes pregnant and birthing people.[473] The HRSA governing statutes relied upon here also offer clear direction for the Secretary to implement programs to improve maternal health.[474]

Importantly, an agency may be less constrained by the courts when issuing guidance. *Loper Bright Enterprises* considered regulations, and it remains to be seen how this decision will govern agency guidance, particularly guidance that is considered controlling guidance. Previously, controlling guidance has been treated similarly to regulations in administrative law, and such guidance has been subject to APA requirements, such as notice and comment rulemaking.[475] Informal guidance, however, such as providing recommendations and best practices, has not been held

Regulation, BROOKINGS INST. (Aug. 18, 2022), https://www.brookings.edu/articles/judicial-deference-and-the-future-of-regulation/ [https://perma.cc/67F9-G7HX].

[468] *See, e.g.*, Bondi v. VanDerStok, 145 S. Ct. 857, 874 (2025) (citing *Loper Bright*, 144 S. Ct. at 2262).

[469] CONG. RSCH. SERV., R41390, DISCRETIONARY SPENDING UNDER THE AFFORDABLE CARE ACT 1 (ACA) (2017).

[470] *See* BRIGANCE ET AL., *supra* note 290, at 4 (providing policy solution and actions related to maternal health that are possible under the ACA and Medicaid).

[471] *See* 42 U.S.C. § 254c-8.

[472] 42 U.S.C. § 18022(b)(1).

[473] ALLSBROOK & AHMED, *supra* note 205, at 4–5; *see supra* notes 145–46 and accompanying text.

[474] *See* 42 U.S.C. § 254c-8.

[475] *See, e.g.*, Nat'l Mining Ass'n v. McCarthy, 758 F.3d 243, 251–52 (D.C. Cir. 2014) (explaining that guidance imposing legal requirements should be subject to rulemaking requirements); *see also* 5 U.S.C. §§ 702, 706(2)(D) (providing a process for an individual to claim that agency guidance should have gone through notice and comment rulemaking).

to the same standards as regulations.[476] As explained above, courts are still tasked with affording agencies deference for policy decisions.[477]

HHS should maintain its authority to undertake oversight and enforcement actions, including to withhold federal funding for violation of civil rights protections, namely utilizing the ACA Section 1557 and the Medicare and Medicaid conditions of participation.[478] Subsequently, OCR should also have more flexibility to issue guidance explaining behaviors prohibited under the ACA Section 1557. Finally, it appears that HHS retains the ability to incentivize good behavior: For example, HHS has significant flexibility to designate or not designate a hospital as birthing friendly and to determine the criteria that a hospital must meet to be worthy of this discretionary designation.[479]

2. Major Questions Doctrine

The major questions doctrine has already impacted federal regulations, including health regulations. This doctrine, as it has been applied, provides that the Court will presume Congress did not intend to grant federal agencies authority to rule on politically and economically significant policy decisions.[480] If the Court finds that an agency has undertaken rulemaking in an area that is politically and economically significant, then the Court will look for "'clear congressional authorization'" to the federal agency.[481]

a. What Is Major?

The Supreme Court has not outlined a bright line rule as to what it considers politically and economically significant; however, recent cases are instructive. Each of the regulations the Court struck down came with significant costs and/or required a drastic shift in private actions within major sectors, such as housing and employment. The Court has stated, "We presume that 'Congress intends to make major policy decisions itself, not leave those decisions to agencies.'"[482] In

---

476 *See, e.g.*, Syncor Int'l Corp. v. Shalala, 127 F.3d 90, 94 (D.C. Cir. 1997) ("By issuing a policy statement, an agency simply lets the public know its current enforcement or adjudicatory approach."); *see also* United States v. Mead Corp., 533 U.S. 218, 233–34 (2001) (holding that certain guidelines are not subject to *Chevron* deference but were subject to *Skidmore* deference).

477 *See supra* notes 436, 459–62 and accompanying text.

478 *See supra* notes 161–65 and accompanying text.

479 *See* Hellmann, *supra* note 253.

480 *See* FDA v. Brown & Williamson Tobacco Corp., 529 U.S. 120, 133 (2000) ("[W]e must be guided to a degree by common sense as to the manner in which Congress is likely to delegate a policy decision of such economic and political magnitude to an administrative agency.").

481 West Virginia v. EPA, 142 S. Ct. 2587, 2609 (2022) (quoting Utility Air Regul. Grp. v. EPA, 573 U.S. 302, 324 (2014)); *Brown & Williamson*, 529 U.S. at 133.

482 *West Virginia*, 142 S. Ct. at 2609 (quoting U.S. Telecom Ass'n v. FCC, 855 F.3d 381, 419 (D.C. Cir. 2017) (Kavanaugh, Circuit Justice, dissenting)); *see also U.S. Telecom Ass'n*,

West Virginia v. EPA, the Supreme Court declared that it will assess whether an exercise of regulatory power poses a "major question."[483] Two regulations were at issue in that case addressing carbon dioxide pollution from new and existing power plants.[484] In striking down the regulations, the Court found the proposed rule would cost power plants billions of dollars to comply, lead to the coal-fired plants ceasing operations, and "eliminate tens of thousands of jobs across various sectors."[485] In another recent case, the Court held that the Higher Education Relief Opportunities for Students (HEROES) Act of 2003 did not grant authority to the Secretary of Education to forgive student loan debt in response to the COVID-19 pandemic.[486] The Secretary's action would have resulted in the cancelation of $430 billion in student loan debt, impacting 43 million borrowers.[487]

Healthcare and public health regulations have been analyzed under the major questions doctrine. For instance, in *FDA v. Brown & Williamson Tobacco Corp.*, the Court concluded that the Secretary of Health did not have the authority to ban—or even regulate—tobacco.[488] In *National Federation of Independent Business v. Department of Labor*, the Court found the Secretary of Labor did not have the authority under the Occupational Safety and Health Administration (OSHA) to temporarily require employers to mandate that their employees either receive the COVID-19 vaccine or take a COVID-19 test weekly.[489] The Court stated this mandate would have impacted approximately 84 million workers.[490] Similarly, the Court concluded in *Alabama Ass'n of Realtors v. Department of Health & Human Services* that the CDC did not have the authority to issue a nationwide moratorium on evictions during the COVID-19 pandemic.[491] In each of these instances, the Supreme Court concluded the agencies could not take such politically and economically significant actions without explicit congressional authority.

In sum, regulatory actions have been "major" to the Court when they have

855 F.3d at 419 (Kavanaugh, Circuit Justice, dissenting) (explaining that the major questions doctrine is grounded in two presumptions: "(i) a separation of powers-based presumption against the delegation of major lawmaking authority from Congress to the Executive Branch . . . and (ii) a presumption that Congress intends to make major policy decisions itself, not leave those decision to agencies").

[483] *See West Virginia*, 142 S. Ct. at 2610.

[484] *Id.* at 2601, 2605.

[485] *Id.* at 2604, 2612–13.

[486] Biden v. Nebraska, 143 S. Ct. 2355, 2368 (2023).

[487] *Id.* at 2362.

[488] FDA v. Brown & Williamson Tobacco Corp., 529 U.S. 120, 161 (2000).

[489] Nat'l Fed'n of Indep. Bus. v. Dep't of Lab., 142 S. Ct. 661, 662–63 (2022).

[490] *Id.* at 662.

[491] Ala. Ass'n of Realtors v. Dep't of Health & Hum. Servs., 141 S. Ct. 2485, 2488–89 (2021).

been deemed expensive and represent a seismic shift in how the federal agency currently administers a benefit or requirement. The oversight and enforcement recommendations offered in this Article are likely to save—not cost—the government money, particularly if HHS withholds federal funding for low-quality, ineffective care. While cost modeling is outside of the scope of this Article, the policy recommendations to improve the quality of care and avoid perverse payment incentives, including bundling payments and implementing delivery system reform models, have previously been cost-effective and cost-saving.[492] Expanding the maternal health workforce, implementing coverage requirements, and conducting research are likely to be associated with a cost, but the agency has previously undertaken similar actions that have been upheld.[493] Therefore, the policy recommendations offered here should not be considered politically and economically significant enough to be struck down under the major questions doctrine.

b. What Is Clear?

If the Court finds that a regulatory action does indeed impose a major question, the Court will consider whether the agency is acting pursuant to "'clear congressional authorization.'"[494] To conclude that a statute authorizes a federal regulation, the statute must present "something more than a merely plausible textual basis."[495] The Court has stated it will rely upon standard statutory interpretation principles, which involve reading the statute in context.[496] Reviewing major question doctrine cases, the Court appears to frequently consider the following factors to determine whether Congress intended to grant the stated

---

[492] *See, e.g.*, Terry Shih, Lena M. Chen & Brahmajee K. Nallamothu, *Will Bundled Payments Change Health Care? Examining the Evidence Thus Far in Cardiovascular*, 131 AHA: CIRCULATION 2151, 2152 (2015) (discussing the positive impact of bundled payments in cardiovascular care).

[493] For instance, the Women's Preventive Services has largely been a creation of HHS. While there have been over 100 complaints filed against the Women's Preventive Services requirement to cover contraceptives, including four cases heard before the Supreme Court, the courts have largely afforded the promulgating tri-agencies (HHS, the Department of Labor, and the Department of Treasury) deference to define the services that must be covered and the plans that must cover these services. In the most recent Supreme Court case addressing the women's preventive benefit, *Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania*, the Court upheld broad religious and moral exemptions to the contraceptive coverage requirement afforded under the Trump Administration. 140 S Ct. 2367, 2381–82 (2020). The decision was a 7–2 decision, and the entire Court—even the dissent—agreed the agency has the authority to identify the services that must be covered; the difference of opinion was over whether this authority extended to allowing for exemptions. *Id.* at 2381–82, 2405.

[494] West Virginia v. EPA, 142 S. Ct. 2587, 2609 (2022) (quoting Utility Air Regul. Grp. v. EPA, 573 U.S. 302, 324 (2014)).

[495] *Id.*

[496] *See* Davis v. Mich. Dep't of Treasury, 489 U.S. 803, 809 (1989); FDA v. Brown & Williamson Tobacco Corp., 529 U.S. 120, 133 (2000).

authority: (1) the statutory language; (2) the congressional record on related policies; and (3) the agency's own record in interpreting the statute.[497]

In *West Virginia*, the EPA could only point to a statute authorizing it to establish emissions caps at a level reflecting "the best system of emission reduction," not authorization to establish a cap-and-trade "system," specifically.[498] The Court concluded this language was not sufficient to allow the EPA authority to implement the cap-and-trade system as it intended.[499] Once the Court in *Biden v. Nebraska* determined that forgiving billions of dollars in student loans was politically and economically significant, the Court went on to find that the Secretary of Education's congressionally granted authority to "'waive or modify any statutory or regulatory provision applicable to the student financial assistance programs'" did not include the ability to discharge the debt of most borrowers and essentially create, in the Court's view, a new student loan forgiveness program.[500] In *Brown & Williamson*, the Court found the FDA did not have the specific authority to regulate or ban cigarettes and smokeless tobacco because these products were neither drugs nor devices, which the statute permitted the agency to regulate.[501]

There have been decisions where the Court has considered the context of the statute and not just a statute's text. In *King v. Burwell*, the Court upheld HHS' authority to apply federal tax credits to the federal health insurance exchange, despite the fact that the statute only explicitly afforded tax credits to state health insurance marketplaces.[502] The Court found, when reading the ACA in its entirety, the regulation was consistent with Congress' intent.[503] Of course, the makeup of the Court has changed since *King* was decided in 2015, but it does suggest that where there is a major question, the Court has a history of looking at the statute's text as a whole.

In short, to ensure regulations and administrative policies can withstand a judicial challenge, agencies will benefit from identifying clear statutory authorities, but the Court might examine the statutory language in context. Even if the Court were to consider the policy recommendations offered in this Article as raising "major questions," there are clear statutory authorities to implement the policy recommendations. The specific authorizing language is discussed in Part II. The

---

[497] *See Davis*, 489 U.S. at 809; *Brown & Williamson*, 529 U.S. at 133; *West Virginia*, 142 U.S. at 2609.

[498] *West Virginia*, 142 U.S. at 2599, 2604, 2514–16.

[499] *Id.* at 2615–16.

[500] Biden v. Nebraska, 143 S. Ct. 2355, 2368 (2023) (quoting 20 U.S.C. § 1098bb(a)(1)).

[501] *Brown & Williamson*, 142 U.S. at 126, 133, 137. The had FDA promulgated regulations governing the promotion, labeling, and accessibility of tobacco products for children and adolescents. *Id.* at 126–27. The FDA concluded that nicotine was a "drug," and cigarettes and smokeless tobacco were "devices." *Id.*

[502] King v. Burwell, 576 U.S. 473, 497–98 (2015).

[503] *Id.* at 497.

recommendations are further supported when considering the congressional intent behind the ACA, Medicaid, and HRSA's governing statutes.

Regulations should also not appear to be an attempt to work around Congress' decision to decline to enact a similar policy. The Court has taken into account when Congress has considered and declined to enact a policy similar to what the agency is proposing.[504] Justice Gorsuch's concurrence in *West Virginia* emphasizes this point stating the Court, in assessing congressional intent, would consider whether "Congress has 'considered and rejected'" related bills, and if so, a regulation to accomplish the same could be perceived as an attempt to "'work around'" the legislative process.[505] The majority in *Alabama Ass'n of Realtors* did just this when it considered the fact that Congress had declined to reextend the moratorium on evictions after previously extending the moratorium.[506] Similarly, in *National Federation of Independent Business*, the Court noted that Congress had not enacted a vaccine or test mandate, even though it had passed other significant COVID-19 legislation.[507] In *Nebraska*, the Court even pointed to statements made by congressmembers regarding the President's authority to cancel student loans.[508] In *Brown & Williamson*, the Court went as far as to say that it would "consider in greater detail the tobacco-specific legislation that Congress has enacted over the past 35 years."[509]

Regulations are more likely to be permitted if consistent with long-standing agency interpretations. Therefore, it will be valuable if regulators can compare proposed regulations to existing agency interpretations and regulations. Despite the Court previously stating that any agency's interpretation is not "carved in stone,"[510] the Court in recent decisions considered whether a regulation expands an agency's authority compared to previous interpretations of the same authority.[511] In *West Virginia*, the Court also stated that in deciding whether a new agency regulation poses a major question, the Court will also review the administrative history.[512] The Court seemed to take issue with the EPA shifting its approach to implementing the statute 50 years after its enactment.[513] In *Brown & Williamson*, the Court pointed out that since 1914, the FDA had indicated that it did not have the authority to

---

[504] *See West Virginia*, 142 U.S. at 2614.

[505] *Id.* at 2620–21 (Gorsuch, J., concurring) (first quoting *Brown & Williamson*, 529 U.S. at 144; then quoting Utility Air Regul. Grp. v. EPA, 573 U.S. 302, 324 (2014)).

[506] Ala. Ass'n of Realtors v. Dep't of Health & Hum. Servs., 141 S. Ct. 2485, 2486–87 (2021).

[507] Nat'l Fed'n of Indep. Bus. v. Dep't of Lab., 142 S. Ct. 661, 664–65 (2022).

[508] Biden v. Nebraska, 143 S. Ct. 2355, 2374 (2023).

[509] *Brown & Williamson*, 529 U.S. at 143.

[510] Chevron U.S.A. v. Nat. Res. Def. Council, Inc., 467 U.S. 837, 863 (1984).

[511] *See* City of Arlington v. FCC, 569 U.S. 290, 297 (2013); Loper Bright Enters. v. Raimondo, 144 S. Ct. 2244, 2251–52 (2024); *Brown & Williamson*, 529 U.S. at 156–57.

[512] West Virginia v. EPA, 142 S. Ct. 2587, 2607–08 (2022).

[513] *See id.* at 2599, 2602, 2610.

regulate tobacco.[514] In *National Federation of Independent Business*, OSHA had only used its authority to issue emergency temporary standards nine times since 1970, and only once had the measure been upheld in its entirety.[515] The Court in *Nebraska* also considered that the Secretary had previously only used its authority to "modify" financial assistance programs to implement procedural changes, compared to the regulations at issue, which altered two statutory sections and three regulations.[516]

Most of the regulatory actions recommended in this Article are either consistent with long-standing agency practice or pursuant to a recently enacted statute. For instance, while the ACA is over 15 years old, it is relatively young compared to the statutes at issue in major questions doctrine jurisprudence.[517] The regulations pursuant to the Medicaid Act are also not novel interpretations, but amendments to existing regulations. Similarly, adopting the recommendations pursuant to the HRSA governing statutes would represent an amendment to an existing program. Even the recent cases discussed have afforded more deference to long-standing agency interpretations. Consistent with its precedent, the Court should afford an agency more leeway to promulgate regulations given the regulations do not depart from long-standing agency interpretations of a statute.

CONCLUSION

"Kira deserved so much better."
—Charles Johnson[518]

Charles Johnson, Kira Dixon Johnson's husband, tries to ensure his sons know about their mother.[519] Ms. Johnson was a businesswoman.[520] She spoke five languages and had a pilot's license. She would skydive as a hobby. Ms. Johnson's death represents a loss for her family but also a loss to her community and the

[514] *Brown & Williamson*, 529 U.S. at 157.

[515] Nat'l Fed'n of Indep. Bus. v. Dep't of Lab., 142 S. Ct. 661, 663 (2022).

[516] Biden v. Nebraska, 143 S. Ct. 2355, 2368–69 (2023). According to the Court, "[e]xamples include reducing the number of tax forms borrowers are required to file, extending time periods in which borrowers must take certain actions, and allowing oral rather than written authorizations." *Id.* at 2369.

[517] *Cf. West Virginia*, 142 S. Ct. at 2599 (examining regulations where the agency was seeking to reinterpret a statute after 50 years).

[518] Pahr, *supra* note 2.

[519] Elizabeth Chuck, *'An Amazing First Step': Advocates Hail Congress's Maternal Mortality Prevention Bill*, NBC NEWS (Dec. 19, 2018, at 02:38 PST), https://www.nbcnews.com/news/us-news/amazing-first-step-advocates-hail-congress-s-maternal-mortality-prevention-n948951 [https://perma.cc/C4TP-ZWX6].

[520] *Id.*

nation.[521] Following his wife's death, Mr. Johnson became a birth justice advocate and founded a nonprofit organization.[522] The organization's primary focus has been pushing for legal reform to address racial maternal health disparities.[523]

A regulatory approach to advancing maternal health is only one approach to solving this crisis, but it is a necessary intervention. Birth justice requires meaningful autonomy in birthing decisions and experiences—and this cannot be realized without affordable access to nondiscriminatory care and services. Enacting evolving, nuanced policies responsive to this public health crisis is within the expertise of federal agencies. To be clear, comprehensive health reform that meaningfully centers health equity and accompanying legal rights are also necessary to achieve birth justice. This will require sweeping legislative and court reform, but pregnant and birthing people cannot wait for such long-term reform. Administrative actions remain necessary even in the face of unprecedented barriers. As the federal government is being dismantled, it is important to remember those opportunities that could be foregone—and more importantly, the lives that could be lost unnecessarily.

While the administrative actions outlined within this Article should not be considered major, implementing them would be meaningful. Pursuing these policies would reflect a clear intent to pursue birth justice: Birth justice requires that women and birthing people be free from discrimination, and holding providers and other health care professionals accountable, including through removing substantial funding, can help prevent this behavior. Birth justice requires having access to high-quality health care, and providing financial incentives, such as linking payment to the quality of care, has been demonstrated to improve care. Birth justice also requires a meaningful choice in deciding where and who assists during the prenatal, labor and delivery, and postpartum periods, and policies to expand the maternity care workforce advance this goal. Finally, birth justice requires a meaningful choice in the care received, and most people in the United States will not have a meaningful choice without insurance coverage to pay for desired services. These administrative policies in isolation, like any policy, will not achieve birth justice—but each will help advance the goal.

---

[521] Pahr, *supra* note 2.

[522] *Id.*; *4Kira4Moms: Our Story*, 4KIRA4MOMS, https://4kira4moms.com/our-story/ [https://perma.cc/M95E-7U4T] (last visited Jan. 12, 2026) (explaining that Mr. Johnson went on to found 4Kira4Moms, an organization with a "mission to advocate for improved maternal health policies and regulations, to educate the public about the impact of maternal mortality in communities, provide peer support to victims' families, and promote the idea that maternal mortality should be viewed, and discussed as a human rights issue").

[523] *4Kira4Moms: Our Story*, *supra* note 522.